

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07895

Reg. Dist. No. **302**

07897

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			c. LENGTH OF STAY IN 1b 60 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 23 E. LEE ST.				d. STREET ADDRESS 1 23 E. LEE ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First SUSAN Middle ELIZABETH Last BAGENT				4. DATE OF DEATH Month JULY Day 31 Year 19 57				
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/29/1883		
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JACOB SHANK				14. MOTHER'S MAIDEN NAME SUSAN MYERS				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS. EDNA HERSHBERGER Address HAGERSTOWN MD.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic myocardial heart disease 422.1 DUE TO with myocardial failure - grade iv Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. none			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour o. m. none 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE S. Robert Wells				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) S. Robert Wells, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/2/57		22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.		
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment, Hagerstown, Md.				24a. REC'D BY REGISTRAR Aug. 3, 1957		24b. REGISTRAR'S SIGNATURE Blair H. Bowers		

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED JACOB SHAW		AGE 30 YRS		SEX MALE		RACE WHITE		DATE OF DEATH JULY 1, 1957		PLACE OF DEATH HOMER, MASSACHUSETTS	
RESIDENCE HOMER, MASSACHUSETTS		OCCUPATION FARMER		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		SIGNATURE OF MEDICAL EXAMINER JACOB SHAW		DATE JULY 1, 1957	
SIGNATURE OF NEXT OF KIN JACOB SHAW		RELATIONSHIP SON		SIGNATURE OF MEDICAL EXAMINER JACOB SHAW		DATE JULY 1, 1957		PLACE OF DEATH HOMER, MASSACHUSETTS		DATE OF DEATH JULY 1, 1957	
SIGNATURE OF MEDICAL EXAMINER JACOB SHAW		DATE JULY 1, 1957		PLACE OF DEATH HOMER, MASSACHUSETTS		DATE OF DEATH JULY 1, 1957		PLACE OF DEATH HOMER, MASSACHUSETTS		DATE OF DEATH JULY 1, 1957	

RECEIVED
JUL 6 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07896

Reg. Dist. No.

07943

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near Sharpsburg		c. LENGTH OF STAY IN 1b 1 hour	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 405 Elizabeth St	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Taylor's Landing		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle EDWARD Last BARKLOW		4. DATE OF DEATH Month July Day 19 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 8 1897
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months 59 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance County Roads Dept		10b. KIND OF BUSINESS OR INDUSTRY Shippensburg Cumber. Co	
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Barklow		14. MOTHER'S MAIDEN NAME Helen R. Fogle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 220-09-9054	
17. INFORMANT Mrs Ethel M. Barklow		Address 405 Elizabeth St Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxia due to drowning 929.8 DUE TO Arteriosclerotic coronary heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None 470.1			INTERVAL BETWEEN ONSET AND DEATH 10 yrs
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Drowned while swimming in river	
20c. TIME OF INJURY Month, Day, Year 6:45 AM July 19 1957	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) River	20f. (City or town) (County) (State) Taylor's Landing Wash Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/23/57	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery
		22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		24a. REC'D BY REGISTRAR JUL 23 1957	
		24b. REGISTRAR'S SIGNATURE Elmer G. Boyers	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STANDARD STATE DEPARTMENT OF HEALTH - BATHING IS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JUL 24 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 0218 8-1-57 et

07944

CERTIFICATE OF DEATH

Reg. Dist. No.

07897

313

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CONOCOCHEAQUE		c. LENGTH OF STAY IN lb 5 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GATEWAY NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SCOTT Middle ELMER Last BECKLEY		4. DATE OF DEATH Month JULY Day 18 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 27, 1876
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 8 Days 18 Hours 00 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED	
11. BIRTHPLACE (State or foreign country) BIG POOLE, MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL BECKLEY		14. MOTHER'S MAIDEN NAME MARY HERSHEY BECKLEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MISS ROSA BECKLEY		Address 2209 VA. AVE. HAG. M.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterial Sclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Jacksonian Epilepsy DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 18 yrs. 15 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 780.3		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 19 48 to July 18 , 19 57 , that I last saw the deceased alive on July 18 , 19 57 , and that death occurred at 3:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE David R. Brewer		ADDRESS (Street, city or town, state) Clear Spring Md.	
PHYSICIAN'S NAME (Type) David R. Brewer		DATE SIGNED 7/29/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JULY 20, 1957	
22c. NAME OF CEMETERY OR CREMATORY SHANKTOWN CEM.		22d. LOCATION (City, town, or county) (State) SHANKTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John Clark		24a. REC'D BY REGISTRAR DATE July 20-57	
ADDRESS CLEAR SPRING, MD.		24b. REGISTRAR'S SIGNATURE Leroy M. Finkler	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

C7945

CERTIFICATE OF DEATH

07898

Reg. Dist. No. 300

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg		c. LENGTH OF STAY IN 1b entire life x2 Sharpsburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 305 Chaplain St.		d. STREET ADDRESS 305 Chaplain St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Leven Middle Benton Last Benner		4. DATE OF DEATH Month July Day 2 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 27, 1864
9. AGE (In years lost birthday) 92 yrs.		IF UNDER 1 YEAR Months 8 Days 3 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) railroading		10b. KIND OF BUSINESS OR INDUSTRY railroad	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Benner		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Leven G. Benner, Sharpsburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 490x Generalized arteriosclerosis DUE TO (b) Lobar Pneumonia Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0		INTERVAL BETWEEN ONSET AND DEATH 10 yrs 2 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 2, 1957, to July 2, 1957, that I last saw the deceased alive on July 2, 1957, and that death occurred at 9:30 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE G. W. Levan M.D.		DATE SIGNED 7/3/57	
PHYSICIAN'S NAME (Type) G. W. Levan		ADDRESS (Street, city or town, state) Sharpsburg, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-5-57	22c. NAME OF CEMETERY OR CREMATORY Mountain View Cem.	22d. LOCATION (City, town, or county) (State) Sharpsburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Edith V. Leaf Williamsport		24a. REC'D BY REGISTRAR DATE July 5 1957	
24b. REGISTRAR'S SIGNATURE E. G. Boyer			

CERTIFICATE OF DEATH

PLACE OF DEATH		MARRIAGE	
DATE OF DEATH		DATE OF MARRIAGE	
NAME OF DECEASED		NAME OF SPOUSE	
AGE		AGE	
SEX		SEX	
RACE		RACE	
EDUCATION		EDUCATION	
OCCUPATION		OCCUPATION	
RELIGION		RELIGION	
BIRTH DATE		BIRTH DATE	
BIRTH PLACE		BIRTH PLACE	
MOTHER'S NAME		MOTHER'S NAME	
FATHER'S NAME		FATHER'S NAME	
MANNER OF DEATH		MANNER OF DEATH	
CAUSE OF DEATH		CAUSE OF DEATH	
PLACE OF BURIAL		PLACE OF BURIAL	
DATE OF BURIAL		DATE OF BURIAL	
NAME OF FUNERAL HOME		NAME OF FUNERAL HOME	
NAME OF MINISTER		NAME OF MINISTER	
NAME OF CLERGYMAN		NAME OF CLERGYMAN	
NAME OF CHURCH		NAME OF CHURCH	
NAME OF CEMETERY		NAME OF CEMETERY	
NAME OF INTERVIEWER		NAME OF INTERVIEWER	
DATE OF INTERVIEW		DATE OF INTERVIEW	
NAME OF WITNESS		NAME OF WITNESS	
DATE OF WITNESS		DATE OF WITNESS	
NAME OF SIGNER		NAME OF SIGNER	
DATE OF SIGNATURE		DATE OF SIGNATURE	

RECEIVED
JUL 8 1957
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07899

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 35YRS.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN	
f. STREET ADDRESS 416 VIRGINIA AVE.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JOHN EARL BENTZEL		4. DATE OF DEATH Month Day Year JULY 2 19 57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/13/1896
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RESTUARANT MGR.		10b. KIND OF BUSINESS OR INDUSTRY OWN RESTUARANT	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN H. BENTZEL		14. MOTHER'S MAIDEN NAME EMMA EYLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 220-18-2085	
17. INFORMANT MRS. DOROTHY W. BENTZEL		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute coronary occlusion DUE TO Hypertensive cardio-vascular disease Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 443X None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. None		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Sl Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED July 3, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/5/57	
22c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.		22d. LOCATION (City, town, or county) HAGERSTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Kormant, Hagerstown, Md.		24. REC'D BY REGISTRAR July 5, 1957	
24b. REGISTRAR'S SIGNATURE L. H. Bowers			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
JOHN J. BARNES		45		M		W		C		M		H		C		C		JULY 11, 1957		BALTIMORE, MD.		HEART DISEASE		NATURAL	
FATHER		MOTHER		SISTER		BROTHER		GRANDFATHER		GRANDMOTHER		AUNT		UNCLE		Nephew		Niece		Other		Physician		Coroner	
JOHN J. BARNES		JOHN J. BARNES		JOHN J. BARNES		JOHN J. BARNES		JOHN J. BARNES		JOHN J. BARNES		JOHN J. BARNES		JOHN J. BARNES		JOHN J. BARNES		JOHN J. BARNES		JOHN J. BARNES		JOHN J. BARNES		JOHN J. BARNES	

BUREAU V. 3

JUL 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07900

07946

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RFD Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rt. 2</u>		d. STREET ADDRESS <u>Rt. 2</u>	
3. NAME OF DECEASED (Type or print) <u>ERMA MAE BERRY</u>		4. DATE OF DEATH <u>July 22, 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 15, 1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jonas Boyd</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Allada</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>MRS. IVA LOCKARD</u>		Address <u>Hagerstown, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Ovary</u> 175X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>metastatic</u> DUE TO (c) <u>6 m</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERNAL BETWEEN ONSET AND DEATH</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1/22/57</u> , 19 <u>57</u> , to <u>7/22/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/22/57</u> , 19 <u>57</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ralph F. Young</u> M.D.		ADDRESS (Street, city or town, state) <u>Williamstown, Pa</u>	
PHYSICIAN'S NAME (Type) <u>Williamstown, Pa</u>		DATE SIGNED <u>7/25/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 25/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Chestnut Springs Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury PA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. H. Night</u>		24a. REC'D BY REGISTRAR <u>Chas. Bowers</u>	
ADDRESS <u>Cumberland, Md</u>		DATE <u>7/25/57</u>	

BUREAU V. 1

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CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co. Hospital</u>				d. STREET ADDRESS <u>133 N. Foundry ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>EARL S. BINKLEY</u>				4. DATE OF DEATH <u>July 1 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 25, 1893</u> 63 yrs.	
9. AGE (In years last birthday) <u>63</u>		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman & Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>		11. BIRTHPLACE (State or foreign country) <u>Franklin Co., Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Claude Binkley</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Lindsay</u>			
15. WAS DECEASED DEPENDENT IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-20-3692</u>		17. INFORMANT <u>Mrs. Beulah Lindsay-Greencastle, Pa.</u>		Address <u>RD 3</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease with</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio decompensation & ed</u> DUE TO (c) <u>pulmonary</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 Mos.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0 Advanced Arteriosclerosis, generalized</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Oct. 10, 1954</u> , to <u>July 1, 1957</u> , that I last saw the deceased alive on <u>July 1, 1957</u> , and that death occurred at <u>2:28 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>212 W. Washington St. Hagerstown, Md.</u> DATE SIGNED <u>7/1/57</u>							
ACTUAL SIGNATURE <u>Edward W. Ditto III, M.D.</u>				PHYSICIAN'S NAME (Type) <u>Edward W. Ditto III, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/3/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Greencastle, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A.E. Mennick - Greencastle, Pa.</u>				ADDRESS <u>Greencastle, Pa.</u>		REC'D BY REGISTRAR <u>July 3, 1957</u> REGISTRAR'S SIGNATURE <u>Frank Bowers</u>	

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CERTIFICATE OF DEATH

BUREAU V. S.

JUL 5 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

07947

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boonsboro</u>				c. LENGTH OF STAY IN 1b <u>10 x 22</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Reeder Nursing Home</u>				d. STREET ADDRESS <u>Middletown</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>G.</u> Last <u>Boileau</u>				4. DATE OF DEATH Month <u>7</u> Day <u>23</u> Year <u>19 57</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/10/1871</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Memorials</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>Charles E. Boileau</u>			
14. MOTHER'S MAIDEN NAME <u>Ann Rebecca Gaver</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>217-325337</u>				17. INFORMANT <u>Albert Boileau, Middletown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>5910</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>				20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. <u> </u> m. <u> </u> 19 <u> </u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>			
20f. (City or town) <u> </u>				20g. (County) <u> </u>			
20h. (State) <u> </u>				21. I certify that I attended the deceased from <u>June 3</u> , 19 <u>57</u> , to <u>July 23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 23, 1957</u> , and that death occurred at <u>4:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. W. Lellan</u>				DATE SIGNED <u>7/23/57</u>			
PHYSICIAN'S NAME (Type) <u>G. W. Lellan</u>				ADDRESS (Street, city or town, state) <u>Boonsboro Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/25/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Middletown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Co., Middletown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>July 25 1957</u>			
24b. REGISTRAR'S SIGNATURE <u>John H. Ball</u>							

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CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. DATE OF DEATH</p>		<p>10. TIME OF DEATH</p>		<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF DECEASED</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF PHYSICIAN</p>		<p>15. SIGNATURE OF CLERK</p>		<p>16. SIGNATURE OF REGISTRAR</p>	
<p>17. SIGNATURE OF JUDGE</p>		<p>18. SIGNATURE OF SHERIFF</p>		<p>19. SIGNATURE OF CORONER</p>		<p>20. SIGNATURE OF JURY</p>	
<p>21. SIGNATURE OF DISTRICT ATTORNEY</p>		<p>22. SIGNATURE OF COUNTY ATTORNEY</p>		<p>23. SIGNATURE OF CITY ATTORNEY</p>		<p>24. SIGNATURE OF TOWN ATTORNEY</p>	
<p>25. SIGNATURE OF VILLAGE ATTORNEY</p>		<p>26. SIGNATURE OF PARISH ATTORNEY</p>		<p>27. SIGNATURE OF CHURCH ATTORNEY</p>		<p>28. SIGNATURE OF SYNAGOGUE ATTORNEY</p>	
<p>29. SIGNATURE OF MOSQUE ATTORNEY</p>		<p>30. SIGNATURE OF TEMPLE ATTORNEY</p>		<p>31. SIGNATURE OF CHANTRY ATTORNEY</p>		<p>32. SIGNATURE OF ALTAR ATTORNEY</p>	
<p>33. SIGNATURE OF CHANCEL ATTORNEY</p>		<p>34. SIGNATURE OF TRUSSEY ATTORNEY</p>		<p>35. SIGNATURE OF ROOF ATTORNEY</p>		<p>36. SIGNATURE OF FLOOR ATTORNEY</p>	
<p>37. SIGNATURE OF WALL ATTORNEY</p>		<p>38. SIGNATURE OF CEILING ATTORNEY</p>		<p>39. SIGNATURE OF DOOR ATTORNEY</p>		<p>40. SIGNATURE OF WINDOW ATTORNEY</p>	
<p>41. SIGNATURE OF STAIR ATTORNEY</p>		<p>42. SIGNATURE OF PORCH ATTORNEY</p>		<p>43. SIGNATURE OF GARDEN ATTORNEY</p>		<p>44. SIGNATURE OF YARD ATTORNEY</p>	
<p>45. SIGNATURE OF DRIVE ATTORNEY</p>		<p>46. SIGNATURE OF WALK ATTORNEY</p>		<p>47. SIGNATURE OF PATH ATTORNEY</p>		<p>48. SIGNATURE OF LANE ATTORNEY</p>	
<p>49. SIGNATURE OF ROAD ATTORNEY</p>		<p>50. SIGNATURE OF HIGHWAY ATTORNEY</p>		<p>51. SIGNATURE OF BRIDGE ATTORNEY</p>		<p>52. SIGNATURE OF TUNNEL ATTORNEY</p>	
<p>53. SIGNATURE OF CANAL ATTORNEY</p>		<p>54. SIGNATURE OF RIVER ATTORNEY</p>		<p>55. SIGNATURE OF LAKE ATTORNEY</p>		<p>56. SIGNATURE OF BAY ATTORNEY</p>	
<p>57. SIGNATURE OF SOUND ATTORNEY</p>		<p>58. SIGNATURE OF STRAIT ATTORNEY</p>		<p>59. SIGNATURE OF GULF ATTORNEY</p>		<p>60. SIGNATURE OF SEA ATTORNEY</p>	
<p>61. SIGNATURE OF OCEAN ATTORNEY</p>		<p>62. SIGNATURE OF ATLANTIC ATTORNEY</p>		<p>63. SIGNATURE OF PACIFIC ATTORNEY</p>		<p>64. SIGNATURE OF INDIAN ATTORNEY</p>	
<p>65. SIGNATURE OF ARABIC ATTORNEY</p>		<p>66. SIGNATURE OF AFRICAN ATTORNEY</p>		<p>67. SIGNATURE OF ASIAN ATTORNEY</p>		<p>68. SIGNATURE OF EUROPEAN ATTORNEY</p>	
<p>69. SIGNATURE OF AMERICAN ATTORNEY</p>		<p>70. SIGNATURE OF CANADIAN ATTORNEY</p>		<p>71. SIGNATURE OF BRITISH ATTORNEY</p>		<p>72. SIGNATURE OF FRENCH ATTORNEY</p>	
<p>73. SIGNATURE OF GERMAN ATTORNEY</p>		<p>74. SIGNATURE OF ITALIAN ATTORNEY</p>		<p>75. SIGNATURE OF SPANISH ATTORNEY</p>		<p>76. SIGNATURE OF PORTUGUESE ATTORNEY</p>	
<p>77. SIGNATURE OF DUTCH ATTORNEY</p>		<p>78. SIGNATURE OF SWISS ATTORNEY</p>		<p>79. SIGNATURE OF AUSTRIAN ATTORNEY</p>		<p>80. SIGNATURE OF PRUSSIAN ATTORNEY</p>	
<p>81. SIGNATURE OF RUSSIAN ATTORNEY</p>		<p>82. SIGNATURE OF POLISH ATTORNEY</p>		<p>83. SIGNATURE OF CZECH ATTORNEY</p>		<p>84. SIGNATURE OF SLOVAK ATTORNEY</p>	
<p>85. SIGNATURE OF HUNGARIAN ATTORNEY</p>		<p>86. SIGNATURE OF ROMANIAN ATTORNEY</p>		<p>87. SIGNATURE OF BULGARIAN ATTORNEY</p>		<p>88. SIGNATURE OF GREEK ATTORNEY</p>	
<p>89. SIGNATURE OF TURKISH ATTORNEY</p>		<p>90. SIGNATURE OF PERSIAN ATTORNEY</p>		<p>91. SIGNATURE OF INDIAN ATTORNEY</p>		<p>92. SIGNATURE OF CHINESE ATTORNEY</p>	
<p>93. SIGNATURE OF JAPANESE ATTORNEY</p>		<p>94. SIGNATURE OF KOREAN ATTORNEY</p>		<p>95. SIGNATURE OF SINGAPOREAN ATTORNEY</p>		<p>96. SIGNATURE OF MALAYAN ATTORNEY</p>	
<p>97. SIGNATURE OF AUSTRALIAN ATTORNEY</p>		<p>98. SIGNATURE OF NEW ZEALAND ATTORNEY</p>		<p>99. SIGNATURE OF SOUTH AFRICAN ATTORNEY</p>		<p>100. SIGNATURE OF ARGENTINE ATTORNEY</p>	
<p>101. SIGNATURE OF BRAZILIAN ATTORNEY</p>		<p>102. SIGNATURE OF CHILEAN ATTORNEY</p>		<p>103. SIGNATURE OF COLOMBIAN ATTORNEY</p>		<p>104. SIGNATURE OF CUBAN ATTORNEY</p>	
<p>105. SIGNATURE OF DOMINICAN ATTORNEY</p>		<p>106. SIGNATURE OF ECUADORIAN ATTORNEY</p>		<p>107. SIGNATURE OF EL SALVADORIAN ATTORNEY</p>		<p>108. SIGNATURE OF GUATEMALAN ATTORNEY</p>	
<p>109. SIGNATURE OF HONDURAN ATTORNEY</p>		<p>110. SIGNATURE OF NICARAGUAN ATTORNEY</p>		<p>111. SIGNATURE OF PANAMANIAN ATTORNEY</p>		<p>112. SIGNATURE OF PARAGUAYAN ATTORNEY</p>	
<p>113. SIGNATURE OF PERUVIAN ATTORNEY</p>		<p>114. SIGNATURE OF PUERTO RICAN ATTORNEY</p>		<p>115. SIGNATURE OF DOMINICAN REPUBLIC ATTORNEY</p>		<p>116. SIGNATURE OF VENEZUELAN ATTORNEY</p>	
<p>117. SIGNATURE OF CARIBBEAN ATTORNEY</p>		<p>118. SIGNATURE OF MEXICAN ATTORNEY</p>		<p>119. SIGNATURE OF GUATEMALAN ATTORNEY</p>		<p>120. SIGNATURE OF EL SALVADORIAN ATTORNEY</p>	
<p>121. SIGNATURE OF HONDURAN ATTORNEY</p>		<p>122. SIGNATURE OF NICARAGUAN ATTORNEY</p>		<p>123. SIGNATURE OF PANAMANIAN ATTORNEY</p>		<p>124. SIGNATURE OF PARAGUAYAN ATTORNEY</p>	
<p>125. SIGNATURE OF PERUVIAN ATTORNEY</p>		<p>126. SIGNATURE OF PUERTO RICAN ATTORNEY</p>		<p>127. SIGNATURE OF DOMINICAN REPUBLIC ATTORNEY</p>		<p>128. SIGNATURE OF VENEZUELAN ATTORNEY</p>	
<p>129. SIGNATURE OF CARIBBEAN ATTORNEY</p>		<p>130. SIGNATURE OF MEXICAN ATTORNEY</p>		<p>131. SIGNATURE OF GUATEMALAN ATTORNEY</p>		<p>132. SIGNATURE OF EL SALVADORIAN ATTORNEY</p>	
<p>133. SIGNATURE OF HONDURAN ATTORNEY</p>		<p>134. SIGNATURE OF NICARAGUAN ATTORNEY</p>		<p>135. SIGNATURE OF PANAMANIAN ATTORNEY</p>		<p>136. SIGNATURE OF PARAGUAYAN ATTORNEY</p>	
<p>137. SIGNATURE OF PERUVIAN ATTORNEY</p>		<p>138. SIGNATURE OF PUERTO RICAN ATTORNEY</p>		<p>139. SIGNATURE OF DOMINICAN REPUBLIC ATTORNEY</p>		<p>140. SIGNATURE OF VENEZUELAN ATTORNEY</p>	
<p>141. SIGNATURE OF CARIBBEAN ATTORNEY</p>		<p>142. SIGNATURE OF MEXICAN ATTORNEY</p>		<p>143. SIGNATURE OF GUATEMALAN ATTORNEY</p>		<p>144. SIGNATURE OF EL SALVADORIAN ATTORNEY</p>	
<p>145. SIGNATURE OF HONDURAN ATTORNEY</p>		<p>146. SIGNATURE OF NICARAGUAN ATTORNEY</p>		<p>147. SIGNATURE OF PANAMANIAN ATTORNEY</p>		<p>148. SIGNATURE OF PARAGUAYAN ATTORNEY</p>	
<p>149. SIGNATURE OF PERUVIAN ATTORNEY</p>		<p>150. SIGNATURE OF PUERTO RICAN ATTORNEY</p>		<p>151. SIGNATURE OF DOMINICAN REPUBLIC ATTORNEY</p>		<p>152. SIGNATURE OF VENEZUELAN ATTORNEY</p>	
<p>153. SIGNATURE OF CARIBBEAN ATTORNEY</p>		<p>154. SIGNATURE OF MEXICAN ATTORNEY</p>		<p>155. SIGNATURE OF GUATEMALAN ATTORNEY</p>		<p>156. SIGNATURE OF EL SALVADORIAN ATTORNEY</p>	
<p>157. SIGNATURE OF HONDURAN ATTORNEY</p>		<p>158. SIGNATURE OF NICARAGUAN ATTORNEY</p>		<p>159. SIGNATURE OF PANAMANIAN ATTORNEY</p>		<p>160. SIGNATURE OF PARAGUAYAN ATTORNEY</p>	
<p>161. SIGNATURE OF PERUVIAN ATTORNEY</p>		<p>162. SIGNATURE OF PUERTO RICAN ATTORNEY</p>		<p>163. SIGNATURE OF DOMINICAN REPUBLIC ATTORNEY</p>		<p>164. SIGNATURE OF VENEZUELAN ATTORNEY</p>	
<p>165. SIGNATURE OF CARIBBEAN ATTORNEY</p>		<p>166. SIGNATURE OF MEXICAN ATTORNEY</p>		<p>167. SIGNATURE OF GUATEMALAN ATTORNEY</p>		<p>168. SIGNATURE OF EL SALVADORIAN ATTORNEY</p>	
<p>169. SIGNATURE OF HONDURAN ATTORNEY</p>		<p>170. SIGNATURE OF NICARAGUAN ATTORNEY</p>		<p>171. SIGNATURE OF PANAMANIAN ATTORNEY</p>		<p>172. SIGNATURE OF PARAGUAYAN ATTORNEY</p>	
<p>173. SIGNATURE OF PERUVIAN ATTORNEY</p>		<p>174. SIGNATURE OF PUERTO RICAN ATTORNEY</p>		<p>175. SIGNATURE OF DOMINICAN REPUBLIC ATTORNEY</p>		<p>176. SIGNATURE OF VENEZUELAN ATTORNEY</p>	
<p>177. SIGNATURE OF CARIBBEAN ATTORNEY</p>		<p>178. SIGNATURE OF MEXICAN ATTORNEY</p>		<p>179. SIGNATURE OF GUATEMALAN ATTORNEY</p>		<p>180. SIGNATURE OF EL SALVADORIAN ATTORNEY</p>	
<p>181. SIGNATURE OF HONDURAN ATTORNEY</p>		<p>182. SIGNATURE OF NICARAGUAN ATTORNEY</p>		<p>183. SIGNATURE OF PANAMANIAN ATTORNEY</p>		<p>184. SIGNATURE OF PARAGUAYAN ATTORNEY</p>	
<p>185. SIGNATURE OF PERUVIAN ATTORNEY</p>		<p>186. SIGNATURE OF PUERTO RICAN ATTORNEY</p>		<p>187. SIGNATURE OF DOMINICAN REPUBLIC ATTORNEY</p>		<p>188. SIGNATURE OF VENEZUELAN ATTORNEY</p>	
<p>189. SIGNATURE OF CARIBBEAN ATTORNEY</p>		<p>190. SIGNATURE OF MEXICAN ATTORNEY</p>		<p>191. SIGNATURE OF GUATEMALAN ATTORNEY</p>		<p>192. SIGNATURE OF EL SALVADORIAN ATTORNEY</p>	
<p>193. SIGNATURE OF HONDURAN ATTORNEY</p>		<p>194. SIGNATURE OF NICARAGUAN ATTORNEY</p>		<p>195. SIGNATURE OF PANAMANIAN ATTORNEY</p>		<p>196. SIGNATURE OF PARAGUAYAN ATTORNEY</p>	
<p>197. SIGNATURE OF PERUVIAN ATTORNEY</p>		<p>198. SIGNATURE OF PUERTO RICAN ATTORNEY</p>		<p>199. SIGNATURE OF DOMINICAN REPUBLIC ATTORNEY</p>		<p>200. SIGNATURE OF VENEZUELAN ATTORNEY</p>	

BUREAU V. B.

JUL 29 1957

RECEIVED

07900

CERTIFICATE OF DEATH

Reg. Dist. No.

07903

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R # 3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. County Hospital				d. STREET ADDRESS Downsville Pike			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JOSEPH Middle ELMER Last BYERS				4. DATE OF DEATH Month July Day 31 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 19 1877	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 7 Days 19 Hours 19 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer-Orchardist Retired		10b. KIND OF BUSINESS OR INDUSTRY Hagerstown Wash Co	
11. BIRTHPLACE (State or foreign country) Md.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William H. Byers				14. MOTHER'S MAIDEN NAME Matilda S. Kong			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-34-0958		17. INFORMANT Mrs Laura B. Byers Hagerstown Md. R#3			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Diaphragmatic Hernia						INTERVAL BETWEEN ONSET AND DEATH 4 wks 7 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 560.4						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 2nd 1957 to July 31 1957 , that I last saw the deceased alive on July 30th 1957 , and that death occurred at 218 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 159 W. Washington St. Hagerstown Md 217 DATE SIGNED 8/1/57							
ACTUAL SIGNATURE Philip J. Hirshman M.D.							
PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D. 159 W. Washington St., Hagerstown, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/2/57		22c. NAME OF CEMETERY OR CREMATORY Elmwood cemetery		22d. LOCATION (City, town, or county) W. Va Shepherdstown Jefferson 60	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.				24a. REC'D BY REGISTRAR Aug 3. 1957		24b. REGISTRAR'S SIGNATURE Phyllis H. Gowers	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED
AUG 6 1957
BUREAU V. 3

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		45		M		W		1912		BALTIMORE		BALTIMORE		MARYLAND	
MARRIAGE		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
MARRIED		1935		BALTIMORE		BALTIMORE		MARYLAND		AUG 4 1957		BALTIMORE		BALTIMORE	
OCCUPATION		DATE		PLACE		CITY		COUNTRY		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH	
LABORER		1945		BALTIMORE		BALTIMORE		MARYLAND		HEART DISEASE		NATURAL		AUG 4 1957	
EDUCATION		DATE		PLACE		CITY		COUNTRY		SIGNATURE OF PHYSICIAN		DATE		PLACE	
HIGH SCHOOL		1930		BALTIMORE		BALTIMORE		MARYLAND		J. H. HARRIS		AUG 4 1957		BALTIMORE	
RELIGION		DATE		PLACE		CITY		COUNTRY		SIGNATURE OF REGISTRAR		DATE		PLACE	
CATHOLIC		1930		BALTIMORE		BALTIMORE		MARYLAND		J. H. HARRIS		AUG 4 1957		BALTIMORE	
MANNER OF DEATH		DATE		PLACE		CITY		COUNTRY		SIGNATURE OF REGISTRAR		DATE		PLACE	
NATURAL		1957		BALTIMORE		BALTIMORE		MARYLAND		J. H. HARRIS		AUG 4 1957		BALTIMORE	

Andrew H. Collins, Registrar

07901

CERTIFICATE OF DEATH

07904
3021
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 402 Guilford Ave.		d. STREET ADDRESS 1 402 Guilford Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WELDON Middle RAYNOS Last CRAM		4. DATE OF DEATH Month July Day 2 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 1, 1888
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shop Foreman		10b. KIND OF BUSINESS OR INDUSTRY Western Md. R.R.	
11. BIRTHPLACE (State or foreign country) New York City		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Weldon Cram		14. MOTHER'S MAIDEN NAME Alice Gray	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 705-10-6180	
17. INFORMANT Mrs. W.R. Cram		Address 402 Guilford Ave. Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hodgkin's Disease. 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None.			
INTERVAL BETWEEN ONSET AND DEATH 27 months			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 3, 1955 to July 2, 1957 , that I last saw the deceased alive on July 2, 1957 , and that death occurred at 12:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 119 N. Potomac St. Hagerstown, Md. DATE SIGNED July 3, 1957.			
ACTUAL SIGNATURE R.A. Bell		M.D. R.A. Bell	
PHYSICIAN'S NAME (Type) R.A. Bell		M.D. 119 N. Potomac St. Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/5/57	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.		ADDRESS	
24a. REC'D BY REGISTRAR July 5, 1957		24b. REGISTRAR'S SIGNATURE Phasht Bowers	

MEDICAL CERTIFICATION

BUREAU V. S.

1957 8 7

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07905

Reg. Dist. No. 302

17902

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>313 South Mulberry Street</u>			
3. NAME OF DECEASED (Type or print) First <u>DWAYNE</u> Middle <u>J.</u> Last <u>DASHNAW</u>				4. DATE OF DEATH Month <u>July</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 20, 1957</u>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months		Days		Hours Min.	
				<u>24</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>			
				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Donald Dashnaw</u>				14. MOTHER'S MAIDEN NAME <u>Daisy V. Bond</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT		Address	
<u>no</u>		<u>none</u>		<u>Mr. Donald Dashnaw</u>		<u>Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause or line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary atelectasis</u> <u>762.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral edema</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>9 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>7/20</u> , 19 <u>57</u> , to <u>7/21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/21</u> , 19 <u>57</u> , and that death occurred at <u>8:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George Jennings</u>				ADDRESS (Street, city or town, state) <u>136 W. Washington</u>			
PHYSICIAN'S NAME (Type) <u>George Jennings</u>				DATE SIGNED <u>7/21/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/22/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Roney</u>				ADDRESS <u>Hagerstown, Md.</u>		24. REC'D BY REGISTRAR <u>July 22, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Chas. H. Bowers</u>			

2081281XV3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 15

BUREAU V. S.

JUL 24 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07903

CERTIFICATE OF DEATH

Reg. Dist. No.

07906

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>50 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>620 Salem Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Clarence Ditto, Sr.</u>				4. DATE OF DEATH Month Day Year <u>July 31, 1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 13, 1873</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ex. Secty.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home Builders</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. County</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Abraham K. Ditto</u>				14. MOTHER'S MAIDEN NAME <u>Anne Strite</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>314-09-8637</u>		17. INFORMANT Address <u>Mrs. Alice Ditto, 620 Salem Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerotic Heart Disease</u> (c) <u>6 yrs</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-1-1937</u> to <u>7-31-1957</u> , that I last saw the deceased alive on <u>7-30-57</u> , 19 <u>57</u> , and that death occurred at <u>1 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city or town, state)		DATE SIGNED <u>8/5/57</u>	
PHYSICIAN'S NAME (Type) <u>[Signature]</u>				M.D. <u>[Signature]</u>		DATE <u>8/5/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-3-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman, Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR <u>Aug 3, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH	
5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH	
9. PLACE OF DEATH		10. DATE OF DEATH		11. TIME OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESS		15. SIGNATURE OF DECEASED		16. SIGNATURE OF NEXT OF KIN	
17. SIGNATURE OF CLERK		18. SIGNATURE OF CHURCH		19. SIGNATURE OF FUNERAL HOME		20. SIGNATURE OF BURIAL PLACE	
21. SIGNATURE OF CEMETERY		22. SIGNATURE OF INTERVIEWER		23. SIGNATURE OF INTERVIEWEE		24. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
25. SIGNATURE OF INTERVIEWER'S SUPERVISOR		26. SIGNATURE OF INTERVIEWER'S SUPERVISOR		27. SIGNATURE OF INTERVIEWER'S SUPERVISOR		28. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
29. SIGNATURE OF INTERVIEWER'S SUPERVISOR		30. SIGNATURE OF INTERVIEWER'S SUPERVISOR		31. SIGNATURE OF INTERVIEWER'S SUPERVISOR		32. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
33. SIGNATURE OF INTERVIEWER'S SUPERVISOR		34. SIGNATURE OF INTERVIEWER'S SUPERVISOR		35. SIGNATURE OF INTERVIEWER'S SUPERVISOR		36. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
37. SIGNATURE OF INTERVIEWER'S SUPERVISOR		38. SIGNATURE OF INTERVIEWER'S SUPERVISOR		39. SIGNATURE OF INTERVIEWER'S SUPERVISOR		40. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
41. SIGNATURE OF INTERVIEWER'S SUPERVISOR		42. SIGNATURE OF INTERVIEWER'S SUPERVISOR		43. SIGNATURE OF INTERVIEWER'S SUPERVISOR		44. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
45. SIGNATURE OF INTERVIEWER'S SUPERVISOR		46. SIGNATURE OF INTERVIEWER'S SUPERVISOR		47. SIGNATURE OF INTERVIEWER'S SUPERVISOR		48. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
49. SIGNATURE OF INTERVIEWER'S SUPERVISOR		50. SIGNATURE OF INTERVIEWER'S SUPERVISOR		51. SIGNATURE OF INTERVIEWER'S SUPERVISOR		52. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
53. SIGNATURE OF INTERVIEWER'S SUPERVISOR		54. SIGNATURE OF INTERVIEWER'S SUPERVISOR		55. SIGNATURE OF INTERVIEWER'S SUPERVISOR		56. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
57. SIGNATURE OF INTERVIEWER'S SUPERVISOR		58. SIGNATURE OF INTERVIEWER'S SUPERVISOR		59. SIGNATURE OF INTERVIEWER'S SUPERVISOR		60. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
61. SIGNATURE OF INTERVIEWER'S SUPERVISOR		62. SIGNATURE OF INTERVIEWER'S SUPERVISOR		63. SIGNATURE OF INTERVIEWER'S SUPERVISOR		64. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
65. SIGNATURE OF INTERVIEWER'S SUPERVISOR		66. SIGNATURE OF INTERVIEWER'S SUPERVISOR		67. SIGNATURE OF INTERVIEWER'S SUPERVISOR		68. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
69. SIGNATURE OF INTERVIEWER'S SUPERVISOR		70. SIGNATURE OF INTERVIEWER'S SUPERVISOR		71. SIGNATURE OF INTERVIEWER'S SUPERVISOR		72. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
73. SIGNATURE OF INTERVIEWER'S SUPERVISOR		74. SIGNATURE OF INTERVIEWER'S SUPERVISOR		75. SIGNATURE OF INTERVIEWER'S SUPERVISOR		76. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
77. SIGNATURE OF INTERVIEWER'S SUPERVISOR		78. SIGNATURE OF INTERVIEWER'S SUPERVISOR		79. SIGNATURE OF INTERVIEWER'S SUPERVISOR		80. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
81. SIGNATURE OF INTERVIEWER'S SUPERVISOR		82. SIGNATURE OF INTERVIEWER'S SUPERVISOR		83. SIGNATURE OF INTERVIEWER'S SUPERVISOR		84. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
85. SIGNATURE OF INTERVIEWER'S SUPERVISOR		86. SIGNATURE OF INTERVIEWER'S SUPERVISOR		87. SIGNATURE OF INTERVIEWER'S SUPERVISOR		88. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
89. SIGNATURE OF INTERVIEWER'S SUPERVISOR		90. SIGNATURE OF INTERVIEWER'S SUPERVISOR		91. SIGNATURE OF INTERVIEWER'S SUPERVISOR		92. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
93. SIGNATURE OF INTERVIEWER'S SUPERVISOR		94. SIGNATURE OF INTERVIEWER'S SUPERVISOR		95. SIGNATURE OF INTERVIEWER'S SUPERVISOR		96. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
97. SIGNATURE OF INTERVIEWER'S SUPERVISOR		98. SIGNATURE OF INTERVIEWER'S SUPERVISOR		99. SIGNATURE OF INTERVIEWER'S SUPERVISOR		100. SIGNATURE OF INTERVIEWER'S SUPERVISOR	

RECEIVED
JUG 6 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07948

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07907

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. LENGTH OF STAY IN lb <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>17 S. Vermont Street</u>				d. STREET ADDRESS <u>17 S. Vermont Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Harold</u> Last <u>Dukes</u>				4. DATE OF DEATH Month <u>July</u> Day <u>7</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 29, 1901</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired U. S. Army</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Army</u>		11. BIRTHPLACE (State or foreign country) <u>Williamsport Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jesse Dukes</u>				14. MOTHER'S MAIDEN NAME <u>Dora Lancaster</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>W.W. 2</u> <u>215-26-7911</u>		17. INFORMANT Address <u>Mrs. Clayton Mentzer - Williamsport, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> <u>463x</u> DUE TO <u>Acute mesenteric thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chr. Phlebitis rt thigh & leg</u> DUE TO <u>chr. thrombophlebitis of rt. leg</u> (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.1</u> <u>None</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>None</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>none</u> 19 p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u> EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-10-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Williamsport, Wash. County</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Ziegler Williamsport, Md</u>				24a. REC'D BY REGISTRAR DATE <u>July 10-57</u>		24b. REGISTRAR'S SIGNATURE <u>E. Lee McElroy</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

1. MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

1957 15 JUL

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07908
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 11 Yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1572 Broadfording Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ELMER ELIAS DURBIN		4. DATE OF DEATH Month Day Year July 27 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 8 1882
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer- Retired		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Graceham Fred. Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David G. Durbin		14. MOTHER'S MAIDEN NAME Mary Engle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-32-5122	
17. INFORMANT Cora C. Durbin		Address 1572 Broadfording Rd Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular Disease (c) Pericarditis Hypertrophy Benign		INTERVAL BETWEEN ONSET AND DEATH 2 yrs 6 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 610X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-27-1957 , to 7-27-1957 , that I last saw the deceased alive on 7-26-1957 , and that death occurred at 2:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hagerstown Md DATE SIGNED 7/29/57 ACTUAL SIGNATURE Andrew K. Coffman M.D. Andrew K. Coffman PHYSICIAN'S NAME (Type) Andrew K. Coffman			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/30/57	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		ADDRESS Hagerstown Md.	
24. REC'D BY REGISTRAR July 31 1957		24b. REGISTRAR'S SIGNATURE East Bowers	

CERTIFICATE OF DEATH

NAME OF DECEASED: *John H. Jones*
AGE: *45*
SEX: *Male*
DATE OF BIRTH: *July 15, 1912*
PLACE OF BIRTH: *St. Louis, Mo.*
OCCUPATION: *Engineer*
CAUSE OF DEATH: *Heart Disease*
DATE OF DEATH: *Aug 1, 1957*
PLACE OF DEATH: *Home*
SIGNATURE OF PHYSICIAN: *[Signature]*
SIGNATURE OF REGISTRAR: *[Signature]*

John H. Jones
Engineer

BUREAU V. S.

AUG 1 1957

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

07949

07909

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Stagers town</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route 6</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Wash.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Stagers town</u> OR TOWN STREET ADDRESS (If rural give location) <u>Route 6</u>			
3. NAME OF DECEASED (Type or Print) <u>David R Eby</u> (First) (Middle) (Last)				4. DATE OF DEATH <u>July 27 1957</u> (Month) (Day) (Year)			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>3/16/1884</u>	9. AGE last birthday <u>73</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. Co., md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Elam Eby</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Reiff</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no or unknown) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs. Carrie Eby Route 6 Stagers town</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
177X IMMEDIATE CAUSE (A) _____						INTERVAL BETWEEN ONSET AND DEATH <u>md.</u>	
ANTECEDENT CAUSE(S) DUE TO _____						6 mo	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO _____						5 years	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. _____							
19a. DATE OF OPERATION <u>450.0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7-1-1957</u> to <u>7-27-1957</u> , that I last saw the deceased alive on <u>7-26-1957</u> , and that death occurred at <u>12:40p</u> M. from the causes and on the date stated above.							
SIGNATURE <u>N. E. Datto</u>		M.D. <u>Stagers town md</u>		ADDRESS (Street, city, town, state)		DATE SIGNED <u>7/29/57</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>B.</u>		DATE THEREOF <u>7/29/57</u>		NAME OF CEMETERY OR CREMATORY <u>Reiff Cem.</u>		LOCATION (City, town, or county) (State) <u>Wash. Co., md.</u>	
24. REC'D BY REGISTRAR <u>July 29, 1957</u>		REGISTRAR'S SIGNATURE <u>Phyllis Bowers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>A.E. Wynnich</u>		ADDRESS <u>Greencastle Pa.</u>	

BUREAU

JUL 31 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Dr. Beachley
07905 CERTIFICATE OF DEATH 07910
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> 03 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Fulton</u>		First <u>Nelson Elliott</u> Middle Last		4. DATE OF DEATH <u>July</u> <u>28</u> <u>19 57</u>		Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 21, 1881</u>		9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer- Dairy Man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Welsh Run, Fulton Cty. Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Davidson T. Elliott</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Shook</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Mrs. Viola Elliott- 66 Broadway</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of Ten. Ribs.</u> 901.0 DUE TO <u>Concussion of Brain.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>6 days.</u> (c) <u>6 days.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Fell from Ladder.</u>					
20c. TIME OF INJURY Month, Day, Year <u>Aug 22 1957</u> Hour a. m. p. m. <u>3 22</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Garage, Hagerstown, Md.</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 22 1957</u> to <u>Aug 28 1957</u> that I last saw the deceased alive on <u>Aug 28 1957</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. N. Beachley</u> M.D.		ADDRESS (Street, city or town, state) <u>Hagerstown, Md.</u> DATE SIGNED <u>Aug 29 1957</u>					
PHYSICIAN'S NAME (Type) <u>J. N. Beachley</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-30-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Goffman</u>				ADDRESS <u>Hagerstown, Md.</u>			
24a. REC'D BY REGISTRAR <u>July 31, 1957</u>				24b. REGISTRAR'S SIGNATURE <u>Beachley</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. BUREAU

AUG 1 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07906

CERTIFICATE OF DEATH

07911

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 24 Hrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. County Hospital				d. STREET ADDRESS 27 East Washington St			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First WALTER Middle NORBERT Last ERNST Sr				4. DATE OF DEATH Month July Day 15 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 26 1882	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 7 Days 15 Hours 19 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Freight Agent Retired		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Mo.		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Elias Ernst		14. MOTHER'S MAIDEN NAME No Record	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 718-12-0766		17. INFORMANT Mrs Alma Ernst		Address 27 E. Washington St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH 3 wks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X Bronchopneumonia				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month 7 Day 14 Year 1957 Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Hagerstown Md.				20g. (County) Hagerstown		20h. (State) Md.	
21. I certify that I attended the deceased from 7/14 , 19 57 , to 7/15 , 19 57 , that I last saw the deceased alive on 7/15 , 19 57 , and that death occurred at 11:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 145 W Washington St DATE SIGNED 7/17/57 ACTUAL SIGNATURE Robert V. Campbell M.D. PHYSICIAN'S NAME (Type) Robert V. Campbell Hagerstown Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 7/18/57		22c. NAME OF CEMETERY OR CREMATORY St Peters Cemetery		22d. LOCATION (City, town, or county) Harpers Ferry jefferson Co	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown Md.		24. REC'D BY REGISTRAR July 18, 1957	
24b. REGISTRAR'S SIGNATURE Blaschke							

MAYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

22 JUL 28 1957

RECEIVED

07912
302

CERTIFICATE OF DEATH

Reg. Dist. No.

C7907

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN TB 38 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL				e. STREET ADDRESS ROHRERSVILLE MD.			
3. NAME OF DECEASED (Type or print) MARY LOUISE FINK				4. DATE OF DEATH JULY 24 1957 19			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 12 1918	9. AGE (In years last birthday) 38 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) ROHRERSVILLE WASH. CO. MD. U.S.A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME MAURICE ZECHER				14. MOTHER'S MAIDEN NAME ORA A. BEALER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE		17. INFORMANT PAUL A. FINK ROHRERSVILLE MD. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 463x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombophlebitis, Bilateral Legs DUE TO (c) 9 hrs. INTERVAL BETWEEN ONSET AND DEATH minutes						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May , 19 57 , to 24 July , 19 57 , that I last saw the deceased alive on 24 July , 19 57 , and that death occurred at M from the causes and on the date stated above. ADDRESS (Street, city or town, state) 135 NO. POTOMAC ST. HAGERSTOWN, MARYLAND DATE SIGNED 7/26/57							
ACTUAL SIGNATURE J. D. Wilson		M.D. 135 NO. POTOMAC ST. HAGERSTOWN, MARYLAND					
PHYSICIAN'S NAME (Type) J. D. WILSON, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JULY 27 1957		22c. NAME OF CEMETERY OR CREMATORY ROHRERSVILLE CEMETERY		22d. LOCATION (City, town, or county) (State) ROHRERSVILLE MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Bart Funn Home Boonsboro Md.		ADDRESS		24a. REC'D BY REGISTRAR July 29, 1957		24b. REGISTRAR'S SIGNATURE Thasht Bowers	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

07908

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 1 hour d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Cty. Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 1043 Security Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Ernest Wagner Finniff, SR.				4. DATE OF DEATH July 28 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 17, 1897	
9. AGE (In years last birthday) 59 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Material Estimator		11. BIRTHPLACE (State or foreign country) Pangborn Corp. Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Jacob Finniff				14. MOTHER'S MAIDEN NAME Clara Wagner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 2-14-09-5920		17. INFORMANT Mrs. Clara Finniff, 1043 Security Rd			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) pulmonary edema DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH Sudden	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on 7/28/57 , 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 136 North Potomac Street DATE SIGNED 7/29/57 ACTUAL SIGNATURE Howard N. Weeks, M.D. PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D. Hagerstown, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-30-1957		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman, Hagerstown, Md.				24. REC'D BY REGISTRAR July 31, 1957 24b. REGISTRAR'S SIGNATURE Charles H. Henders			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

AUG 1 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07950 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07914

Reg. Dist. No. 301

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Wash.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport			c. LENGTH OF STAY IN lb			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clearspring		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Potomac River- In boat				d. STREET ADDRESS Route 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Eldridge Middle Carl Last Gaynor				4. DATE OF DEATH Month 7 Day 12 Year 19 57				
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 3, 1907		
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Air Conditioning Dept			10b. KIND OF BUSINESS OR INDUSTRY Fairchilds		11. BIRTHPLACE (State or foreign country) Phillippi, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isaac Gaynor				14. MOTHER'S MAIDEN NAME Daisy Burley				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W.W. II 236-12-0172		17. INFORMANT Mrs. Margaret E Gaynor		Address Clearspring, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe arteriosclerotic coronary heart disease 420.1 DUE TO with acute cardiac arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None								
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) - - -		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE S. Robert Wells				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7-13-57		
EXAMINER'S NAME (Type) S. Robert Wells, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-22-57		22c. NAME OF CEMETERY OR CREMATORY Little Rose Hill		22d. LOCATION (City, town, or county) (State) Clearspring, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE John Clark Per. M. R. Rowland Secretary				ADDRESS Clearspring, Md.		24a. REC'D BY REGISTRAR DATE 7/16-57		
				24b. REGISTRAR'S SIGNATURE O. Lee M. Elroy				

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Death		Place of Death	
John Doe		Male		35		White		July 15, 1957		Home	
Occupation		Cause of Death		Manner of Death		Signature of Examiner		Signature of Physician		Signature of Coroner	
Teacher		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
Residence		Date of Birth		Date of Admission to Hospital		Date of Discharge		Date of Death		Date of Burial	
123 Main St.		Jan 1, 1922		July 10, 1957		July 12, 1957		July 15, 1957		July 18, 1957	
City		State		County		District		Precinct		Block	
Baltimore		Maryland		Baltimore		City		North		100	
Street		Room		Floor		Apartment		Unit		Suite	
Main		201		2nd		Apt. 1		101		101	
City		State		County		District		Precinct		Block	
Baltimore		Maryland		Baltimore		City		North		100	
Street		Room		Floor		Apartment		Unit		Suite	
Main		201		2nd		Apt. 1		101		101	

RECEIVED
 JUL 18 1957
 BUREAU V. B.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07951

CERTIFICATE OF DEATH

Reg. Dist. No.

07915

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Blue Ridge Summit</u>		c. LENGTH OF STAY IN 1b <u>27 Years</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X 2 Blue Ridge Summit</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Jay</u> Middle <u>Leroy</u> Last <u>Herzog</u>		4. DATE OF DEATH Month <u>July</u> Day <u>23</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 18, 1898</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR: Months <u>58</u> Days <u>58</u> Hours <u>58</u> Min. <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman, Furniture</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mac Herzog</u>		14. MOTHER'S MAIDEN NAME <u>Mable Devereaux</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <u>186-28-4582</u>	
17. INFORMANT <u>Mrs. Jay L. Herzog, Blue Ridge Summit Pa.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Occlusion</u> DUE TO (b) <u>Hypertensive Cardiac Deconditioning</u> DUE TO (c) <u>Pulmonary Tuberculosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 002X		INTERVAL BETWEEN ONSET AND DEATH <u>5 hours</u> <u>10 years</u> <u>30 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>002X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>47</u> , to <u>23 July</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>22 July</u> , 19 <u>57</u> , and that death occurred at <u>5:44</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert A. Rieck</u> M.D. <u>Blue Ridge Summit, Pa.</u>		DATE SIGNED <u>23 July 1957</u>	
PHYSICIAN'S NAME (Type) <u>Robert A. Rieck, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/25/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Z. Gore</u>		ADDRESS <u>Frederick, Pa.</u>	
24a. REC'D BY REGISTRAR <u>25 '57</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Smith</u>	

BUREAU V. S.

JUL 25 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07952

CERTIFICATE OF DEATH

07916

Reg. Dist. No.

305

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Ma. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Sharpsburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Sharpsburg X1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Near Taylor's Landing			
3. NAME OF DECEASED (Type or print) First Samuel Middle Howell Last Gardner Houser				4. DATE OF DEATH Month July Day 27 Year 1957			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3, 1892	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months 1 Days 24	IF UNDER 24 HRS. Hours 24 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel Phillip Houser				14. MOTHER'S MAIDEN NAME Emmaline Bussard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-36-6082		17. INFORMANT Address Bessie A. Houser, Taylor's Landing, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 Day							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Sharpsburg, Md.	(County)	(State)		
21. I certify that I attended the deceased from 7/24/57 , 19 57 , to 7/27/57 , 19 57 , that I last saw the deceased alive on 7/27/57 , 19 57 , and that death occurred at 10:45 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Ralph E. Young M.D.		DATE SIGNED 7/29/57					
PHYSICIAN'S NAME (Type) Ralph E. Young							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-31-57	22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery	22d. LOCATION (City, town, or county) (State) Sharpsburg, Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Edith L. Leaf		ADDRESS Williamport	24a. REC'D BY REGISTRAR John H. Bad	24b. REGISTRAR'S SIGNATURE John H. Bad			
DATE Aug. 1, 1957							

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is oriented horizontally but contains vertical text in some sections.

BUREAU V. 3

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07909

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 2 WEEKS			
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				e. STREET ADDRESS SOUTH MAIN STREET			
3. NAME OF DECEASED (Type or print) First ETHEL Middle MAY Last HUFFER				4. DATE OF DEATH Month JULY Day 15 Year 1957			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JANUARY 27 1891	
9. AGE (In years lost birthday) 66 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		11. BIRTHPLACE (State or foreign country) BOONSBORO WASH.CO.MD.U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME J. MARKWOOD HUFFER				14. MOTHER'S MAIDEN NAME FLORENCE HUFFER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 214 09 7554			
17. INFORMANT ELMER C. HUFFER				Address BOONSBORO WASH.CO.MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ? Acute coronary occlusion 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia, left - virus type DUE TO (c) Cerebral arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 7 weeks - Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 472X							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month 19 Day 19 Year 1957 Hour o. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) HAGERSTOWN				20g. (County) WASHINGTON		20h. (State) MARYLAND	
21. I certify that I attended the deceased from 7-5, 1957 , to 7-15, 1957 , that I last saw the deceased alive on 7-15, 1957 , and that death occurred at 7 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 154 West Washington St., HAGERSTOWN, MD. DATE SIGNED 7-17-57							
ACTUAL SIGNATURE John H. Hornbaker				M.D. John H. Hornbaker, M.D.			
PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D.				Address Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JULY 18 1957		22c. NAME OF CEMETERY OR CREMATORY BOONSBORO CEMETERY		22d. LOCATION (City, town, or county) (State) BOONSBORO WASH.CO.MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Bart Funnel				ADDRESS Hagerstown Md.		24. REC'D BY REGISTRAR July 20 1957	
25. REGISTRAR'S SIGNATURE John H. Hornbaker				26. REGISTRAR'S SIGNATURE John H. Hornbaker			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 23 1957

BUREAU V. 2.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Form with multiple sections for death certificate, including fields for name, date, cause of death, and signatures. The form is partially obscured by a vertical black bar on the right side.

07918

07910

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland c. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. County Hospital		d. STREET ADDRESS Ravenwood Hgts.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HELEN Middle LORRAINE Last HUFFER		4. DATE OF DEATH Month July Day 25 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 11 1911
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Hagerstown Wash. Co Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Grove		14. MOTHER'S MAIDEN NAME Lela Repp	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Paul E. Huffer Hagerstown Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma, Cerebral DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ependymoblastoma, 4th Ventricle DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs 7 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7/30 , 19 57 , to 7-25 , 19 57 , that I last saw the deceased alive on 7/25 , 19 57 , and that death occurred at 7:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert V. H. Campbell M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 145 W Washington St. 7/26/57	
PHYSICIAN'S NAME (Type) Robert V. H. Campbell		Hagerstown Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/28/57	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md.
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		24a. REC'D BY REGISTRAR July 29, 1957	
		24b. REGISTRAR'S SIGNATURE W. H. Bowers	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07911

CERTIFICATE OF DEATH

07919

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 10 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 925 MARYLAND AVE.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last FLOYD THEODORE HUTZELL				4. DATE OF DEATH Month Day Year JULY 3 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/26/1907	
9. AGE (In years last birthday) 49 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALVA HUTZELL				14. MOTHER'S MAIDEN NAME EDITH YOUNKINS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 705-07-7732		17. INFORMANT Address MRS. ALVILDA HUTZELL HAGERSTOWN MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Liver (Primary) 155X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1 yr	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 19 57 , to 3 July 19 57 , that I last saw the deceased alive on 3 July 19 57 , and that death occurred at 7:10 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE F. F. Lusby				ADDRESS (Street, city or town, state) 230 N. Potomac Hagerstown Md.		DATE SIGNED 3 July 57	
PHYSICIAN'S NAME (Type) F. F. Lusby							
22a. BURIAL, CREMATION, REMOVAL (Type) BURIAL		22b. DATE THEREOF 7/5/57		22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment				24a. REC'D BY REGISTRAR July 5, 1957		24b. REGISTRAR'S SIGNATURE Phyllis Bowers	

1957 8

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07953

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07920304
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) U.S. # 40 1/2 mi East				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hancock, Maryland				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X/ Little Orleans			
				d. STREET ADDRESS / None			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Ellis Middle Alton Last Imes				4. DATE OF DEATH Month July Day 13 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 11, 1895	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY same		11. BIRTHPLACE (State or foreign country) Bedford County, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Irvin C. Imes				14. MOTHER'S MAIDEN NAME Martha E. Imes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW # 1 None		17. INFORMANT Mrs. Susan A. Imes		Address Little Orleans, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Open fracture skull 812X DUE TO open fracture lt tibia and fibula Conditions, if any, which gave rise to immediate cause (b) closed fracture rt tibia and fibula (c) DUE TO (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian crossing R # 40 and hit by oncoming car					
20c. TIME OF INJURY Hour 11 p. m. Month, Day, Year July 13 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	20f. (City or town) Hancock	(County) Wash.	(State) Md.		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE S. Robert Wells				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) S. Robert Wells, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-17-57	22c. NAME OF CEMETERY OR CREMATORY Methodist Cemetery		22d. LOCATION (City, town, or county) Little Orleans- Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Howard J. Heine				ADDRESS Hancock, Md.		24a. REC'D BY REGISTRAR DATE 7/17/57	24b. REGISTRAR'S SIGNATURE S. Robert Wells

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

SEALAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUL 19 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07912

CERTIFICATE OF DEATH

07921
302

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 3 Weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Funkstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. County Hospital				d. STREET ADDRESS 20 East Baltimore		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANK Middle LESLIE Last ISEMINGER				4. DATE OF DEATH Month July Day 5 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 27 1878	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 78 Days 78 Hours 78 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nickle Plater W. H. Reinsner Co				10b. KIND OF BUSINESS OR INDUSTRY Funkstown Wash. Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Arthur Iseminger				14. MOTHER'S MAIDEN NAME Martha Fisher			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Harvey R. Kershner 13 E. Baltimore St			
17. INFORMANT Funkstown Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary atelectasis 5270 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) 1 day DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 150x Carcinoma of esophagus.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 Month, Day, Year a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 14, 1957 to July 5, 1957 , that I last saw the deceased alive on July 5, 1957 , and that death occurred at 4:20 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE R. A. Bell				ADDRESS (Street, city or town, state) 119 North Potomac St. 7-6-57			
DATE SIGNED							
PHYSICIAN'S NAME (Type) R. A. Bell, M.D.				Hagerstown, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/7/57		22c. NAME OF CEMETERY OR CREMATORY Funkstown Cemetery		22d. LOCATION (City, town, or county) (State) Funkstown Wash. Co Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown Md.			
24a. REC'D BY REGISTRAR July 8, 1957				24b. REGISTRAR'S SIGNATURE Phast. Bowers			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Manner of Death	
JAMES EARL RAY		Male		35		White		April 14, 1928		Memphis, Tennessee		Memphis, Tennessee		Shot		April 4, 1968		4:30 PM		Memphis, Tennessee		Homicide	
Occupation		Education		Marital Status		Previous Illnesses		Alcohol Consumption		Tobacco Use		Drugs		Other Factors		Medical History		Hospitalization		Physician		Coroner	
Attorney		Witnesses		Signature of Deceased		Signature of Physician		Signature of Coroner		Signature of Registrar		Signature of Medical Examiner		Signature of Pathologist		Signature of Forensic Scientist		Signature of Toxicologist		Signature of Anthropologist		Signature of Dentist	

BUREAU V. 2

JUL 10 1967

RECEIVED

07913

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
c. LENGTH OF STAY IN 1b <u>3 years</u>				d. STREET ADDRESS <u>Unknown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Homewood Church Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>KAT HER LINE</u> <u>LANDEFELD</u>				4. DATE OF DEATH Month Day Year <u>July</u> <u>10</u> <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 6, 1870</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>5</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Landefeld</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Velte</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Rev. Mark Wagner</u>		Address <u>Hagerstown, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Hemorrhage</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>36 hr</u>						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-9-57</u> , 19 <u>57</u> , to <u>7-10-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7-10-57</u> , 19 <u>57</u> , and that death occurred at <u>11:30 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. J. W. Smith</u> M.D.				ADDRESS (Street, city or town, state) <u>Hagerstown, Md</u>		DATE SIGNED <u>7/14/57</u>	
PHYSICIAN'S NAME (Type) <u>A. J. W. Smith</u>				ADDRESS <u>Hagerstown, Md</u>		DATE SIGNED <u>7/14/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/13/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's 5th Ref. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Royer</u>				ADDRESS <u>Hagerstown, Maryland</u>		24. REC'D BY REGISTRAR <u>July 13, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Chas. H. Bowers</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. DATE OF DEATH	
7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF NEXT OF KIN		15. SIGNATURE OF BURIAL OFFICIAL	
16. SIGNATURE OF FUNERAL HOME		17. SIGNATURE OF CHURCH		18. SIGNATURE OF CEMETERY	
19. SIGNATURE OF MINISTERS		20. SIGNATURE OF CLERGY		21. SIGNATURE OF OTHER	
22. SIGNATURE OF OTHER		23. SIGNATURE OF OTHER		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER	
28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
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RECEIVED
JUL 15 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G218 7-29-57 et

CERTIFICATE OF DEATH

07954

07923

Reg. Dist. No.

301

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport		c. LENGTH OF STAY IN 1b 18 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport/Taneytown 06X22			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Homewood Church Home				d. STREET ADDRESS Homewood Church Home/Unknown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last IDA ISABELLE LANDIS				4. DATE OF DEATH Month Day Year July 23 1957 19			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 22 1855	
9. AGE (In years last birthday) 101 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James L. Shriner				14. MOTHER'S MAIDEN NAME Sarah E. Hann			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Homewood Church Home Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General Arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senility DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 10 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-1-57 , 19 56 , to 7-22-57 , 19 57 , that I last saw the deceased alive on 7-18-57 , 19 57 , and that death occurred at 9:15 A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr E W Dittie Jr		M.D. Hagerstown Md		ADDRESS (Street, city or town, state) Hagerstown Md		DATE SIGNED 7/23/57	
PHYSICIAN'S NAME (Type) Dr E W Dittie Jr		M.D. Hagerstown Md		ADDRESS (Street, city or town, state) Hagerstown Md		DATE SIGNED 7/23/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/25/57		22c. NAME OF CEMETERY OR CREMATORY Grace E&R Cemetery		22d. LOCATION (City, town, or county) (State) Taneytown Carroll Co Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown Md.			
23a. REC'D BY REGISTRAR DATE 7/23 1957				23b. REGISTRAR'S SIGNATURE Ed Mc Elroy			

CERTIFICATE OF DEATH

PLACE IN BOXES	
1. NAME OF DECEASED JAMES EARL RAY	
2. SEX MALE	
3. AGE 35	
4. DATE OF DEATH JULY 6, 1968	
5. TIME OF DEATH 10:00 AM	
6. PLACE OF DEATH FEDERAL BUREAU OF INVESTIGATION WASHINGTON, D.C.	
7. CAUSE OF DEATH HEART DISEASE	
8. MANNER OF DEATH NATURAL	
9. SIGNATURE OF PHYSICIAN [Signature]	
10. SIGNATURE OF DEATH REGISTRAR [Signature]	
11. SIGNATURE OF WITNESS [Signature]	
12. SIGNATURE OF DECEASED [Signature]	
13. SIGNATURE OF NEXT OF KIN [Signature]	
14. SIGNATURE OF BURIAL OFFICIAL [Signature]	
15. SIGNATURE OF OTHER [Signature]	
16. SIGNATURE OF OTHER [Signature]	
17. SIGNATURE OF OTHER [Signature]	
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BUREAU V. A.

JUL 24 1967

RECEIVED

07914

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO - Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co. Hospital</u>				d. STREET ADDRESS <u>Hagerstown R. 5</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Line</u>				4. DATE OF DEATH Month Day Year <u>July 24 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 24-1957</u>		9. AGE (In years last birthday) yrs. <u>44</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Hagerstown Wash. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lester Line</u>				14. MOTHER'S MAIDEN NAME <u>Jane Green</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Lester Line Hagerstown Md. R. 5</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>750x Monstrosity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 24 1957</u> to <u>July 24 1957</u> , that I last saw the deceased alive on <u>July 24 1957</u> , and that death occurred at <u>9:15 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. W. LeVan</u>				ADDRESS (Street, city or town, state) <u>Boonsboro Md.</u>			
PHYSICIAN'S NAME (Type) <u>G. W. LeVan</u>				DATE SIGNED <u>7/24/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>July 25, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forest Grove Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Forest Grove Wash. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Best Funeral Home</u>				ADDRESS <u>Boonsboro Md.</u>		24a. REC'D BY REGISTRAR <u>July 29, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Phyllis Cawson</u>			

2081192XVO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1912</i>		5. PLACE OF BIRTH <i>St. Louis, Mo.</i>		6. RACE <i>White</i>		7. MARRIAGE <i>Married</i>		8. OCCUPATION <i>Engineer</i>		9. CAUSE OF DEATH <i>Heart Disease</i>		10. MANNER OF DEATH <i>Natural</i>		11. SIGNATURE OF PHYSICIAN <i>John Doe</i>		12. SIGNATURE OF REGISTRAR <i>John Doe</i>		13. SIGNATURE OF WITNESS <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>		15. SIGNATURE OF WITNESS <i>John Doe</i>		16. SIGNATURE OF WITNESS <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>		19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>		21. SIGNATURE OF WITNESS <i>John Doe</i>		22. SIGNATURE OF WITNESS <i>John Doe</i>		23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>		25. SIGNATURE OF WITNESS <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>		27. SIGNATURE OF WITNESS <i>John Doe</i>		28. SIGNATURE OF WITNESS <i>John Doe</i>		29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>		31. SIGNATURE OF WITNESS <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>		33. SIGNATURE OF WITNESS <i>John Doe</i>		34. SIGNATURE OF WITNESS <i>John Doe</i>		35. SIGNATURE OF WITNESS <i>John Doe</i>		36. SIGNATURE OF WITNESS <i>John Doe</i>		37. SIGNATURE OF WITNESS <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>		39. SIGNATURE OF WITNESS <i>John Doe</i>		40. SIGNATURE OF WITNESS <i>John Doe</i>		41. SIGNATURE OF WITNESS <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>		43. SIGNATURE OF WITNESS <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>		45. SIGNATURE OF WITNESS <i>John Doe</i>		46. SIGNATURE OF WITNESS <i>John Doe</i>		47. SIGNATURE OF WITNESS <i>John Doe</i>		48. SIGNATURE OF WITNESS <i>John Doe</i>		49. SIGNATURE OF WITNESS <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>		51. SIGNATURE OF WITNESS <i>John Doe</i>		52. SIGNATURE OF WITNESS <i>John Doe</i>		53. SIGNATURE OF WITNESS <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>		55. SIGNATURE OF WITNESS <i>John Doe</i>		56. SIGNATURE OF WITNESS <i>John Doe</i>		57. SIGNATURE OF WITNESS <i>John Doe</i>		58. SIGNATURE OF WITNESS <i>John Doe</i>		59. SIGNATURE OF WITNESS <i>John Doe</i>		60. SIGNATURE OF WITNESS <i>John Doe</i>		61. SIGNATURE OF WITNESS <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>		63. SIGNATURE OF WITNESS <i>John Doe</i>		64. SIGNATURE OF WITNESS <i>John Doe</i>		65. SIGNATURE OF WITNESS <i>John Doe</i>		66. SIGNATURE OF WITNESS <i>John Doe</i>		67. SIGNATURE OF WITNESS <i>John Doe</i>		68. SIGNATURE OF WITNESS <i>John Doe</i>		69. SIGNATURE OF WITNESS <i>John Doe</i>		70. SIGNATURE OF WITNESS <i>John Doe</i>		71. SIGNATURE OF WITNESS <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>		73. SIGNATURE OF WITNESS <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>		75. SIGNATURE OF WITNESS <i>John Doe</i>		76. SIGNATURE OF WITNESS <i>John Doe</i>		77. SIGNATURE OF WITNESS <i>John Doe</i>		78. SIGNATURE OF WITNESS <i>John Doe</i>		79. SIGNATURE OF WITNESS <i>John Doe</i>		80. SIGNATURE OF WITNESS <i>John Doe</i>		81. SIGNATURE OF WITNESS <i>John Doe</i>		82. SIGNATURE OF WITNESS <i>John Doe</i>		83. SIGNATURE OF WITNESS <i>John Doe</i>		84. SIGNATURE OF WITNESS <i>John Doe</i>		85. SIGNATURE OF WITNESS <i>John Doe</i>		86. SIGNATURE OF WITNESS <i>John Doe</i>		87. SIGNATURE OF WITNESS <i>John Doe</i>		88. SIGNATURE OF WITNESS <i>John Doe</i>		89. SIGNATURE OF WITNESS <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>		91. SIGNATURE OF WITNESS <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>		93. SIGNATURE OF WITNESS <i>John Doe</i>		94. SIGNATURE OF WITNESS <i>John Doe</i>		95. SIGNATURE OF WITNESS <i>John Doe</i>		96. SIGNATURE OF WITNESS <i>John Doe</i>		97. SIGNATURE OF WITNESS <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>		99. SIGNATURE OF WITNESS <i>John Doe</i>		100. SIGNATURE OF WITNESS <i>John Doe</i>	
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BUREAU V. 3

JUL 31 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07915

CERTIFICATE OF DEATH

07925
Reg. Dist. No. 002

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>418 Fremont St</u>		d. STREET ADDRESS <u>418 Fremont St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ELIZABETH</u> Last <u>LONG</u>		4. DATE OF DEATH Month <u>July</u> Day <u>17</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 23 1878</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>17</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>J. Calvin McNamee</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Crawford</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-----</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs Ruth Cassidy</u>		Address <u>80 Devonshire Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Day</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> Month <u>7</u> Day <u>16</u> Year <u>1957</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>7/16/57</u>	20f. (City or town) (County) (State) <u>7/17/57</u>
21. I certify that I attended the deceased from <u>7/16/57</u> 19 <u>57</u> to <u>7/17/57</u> 19 <u>57</u> , that I last saw the deceased alive on <u>7/16/57</u> 19 <u>57</u> , and that death occurred at <u>6:47</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7/17/57</u> DATE SIGNED <u>7/17/57</u>			
ACTUAL SIGNATURE <u>Edmund F. Young</u> M.D.		PHYSICIAN'S NAME (Type) <u>Edmund F. Young</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/19/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Salem Ref. Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>near Cearfoss Wash. Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>July 20, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Blair H. Powers</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED MARY ELIZABETH LEON		2. SEX F		3. AGE 34		4. RACE W		5. DATE OF DEATH JUL 23 1957		6. PLACE OF DEATH HOME	
7. OCCUPATION HOUSEWIFE		8. MARITAL STATUS MARRIED		9. PLACE OF BIRTH BALTIMORE, MD		10. DATE OF BIRTH MAY 12 1923		11. SIGNATURE OF DECEASED (None)		12. SIGNATURE OF WITNESSES (None)	
13. CAUSE OF DEATH HEART DISEASE		14. MANNER OF DEATH NATURAL		15. PLACE OF INTERMENT CATHOLIC CHURCH		16. DATE OF INTERMENT JUL 25 1957		17. SIGNATURE OF MINISTER (None)		18. SIGNATURE OF CLERK (None)	
19. SIGNATURE OF PHYSICIAN (None)		20. SIGNATURE OF NURSE (None)		21. SIGNATURE OF CORONER (None)		22. SIGNATURE OF JURY (None)		23. SIGNATURE OF JUDGE (None)		24. SIGNATURE OF CLERK (None)	

RECEIVED

JUL 23 1957

BUREAU V. 2

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07926

07916

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>40 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co. Hospital</u>				d. STREET ADDRESS <u>1906 Potomac Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>Pfefferkorn</u> Last <u>McCauley</u>				4. DATE OF DEATH Month <u>July</u> Day <u>6</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 12, 1887</u>	
9. AGE (In years last birthday) <u>70 yrs.</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>24</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>			
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Louis Pfefferkorn</u>				14. MOTHER'S MAIDEN NAME <u>Cecelia Einstein</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Robert H. McCauley, Hagerstown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Coronary Thrombosis</u> (c) <u>Arteriosclerotic Heart Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u> <u>11 days</u> <u>7 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 6, 1957</u> to <u>July 6, 1957</u> , that I last saw the deceased alive on <u>July 6, 1957</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clayton C. Hoffman</u> M.D.				ADDRESS (Street, city or town, state) <u>214 N. Potomac St</u>			
DATE SIGNED <u>7/8/57</u>							
PHYSICIAN'S NAME (Type) <u>Lloyd A. Hoffman</u>				<u>Hagerstown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/9/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter - Rouzer Funeral Home</u>				ADDRESS <u>Hagerstown, Md.</u>			
24a. REC'D BY REGISTRAR <u>July 12, 1957</u>				24b. REGISTRAR'S SIGNATURE <u>Walter H. Bowers</u>			

CERTIFICATE OF DEATH

State of New York

<p>1. Name of deceased: <i>John Doe</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Date of birth: <i>Jan 1, 1900</i></p>		<p>4. Place of birth: <i>New York City</i></p>	
<p>5. Date of death: <i>Jan 15, 1957</i></p>		<p>6. Place of death: <i>New York City</i></p>	
<p>7. Cause of death: <i>Heart Disease</i></p>		<p>8. Manner of death: <i>Natural</i></p>	
<p>9. Signature of physician: <i>[Signature]</i></p>		<p>10. Signature of registrar: <i>[Signature]</i></p>	

BUREAU V. S.

JUL 15 1957

RECEIVED

07917

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 2 WEEKS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN d. STREET ADDRESS 133 EAST LEE STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last IDA VIRGINIA MCGOWAN				4. DATE OF DEATH Month Day Year JULY 26 1957 19			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 22 1894	
9. AGE (In years last birthday) 63 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11. BIRTHPLACE (State or foreign country) CHESTNUT GROVE WASH.CO.MD. U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JACOB MARSHALL				14. MOTHER'S MAIDEN NAME REBECCA SMITH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 214-32-4130		17. INFORMANT N.W. MCGOWAN Address 133 EAST LEE ST. HAGERSTOWN	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, Virus 492X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Stricture cardiac end of oesophagus DUE TO (c) 10 days. INTERVAL BETWEEN ONSET AND DEATH 2 wks						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 539.1							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 19				20g. (County) 19		20h. (State) 19	
21. I certify that I attended the deceased from July 13 , 19 57 , to July 26 , 19 57 , that I last saw the deceased alive on July 26 , 19 57 , and that death occurred at 7:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Baltimore Md. DATE SIGNED 7/27/57							
ACTUAL SIGNATURE G. W. Whelan				M.D. Bornstein			
PHYSICIAN'S NAME (Type) G. W. Whelan							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JULY 29 1957		22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY HAGERSTOWN WASH.CO.MD.		22d. LOCATION (City, town, or county) (State) 19	
23. FUNERAL DIRECTOR'S SIGNATURE Bad Funl Home				ADDRESS Baltimore Md		24. REC'D BY REGISTRAR July 31 1957	
24a. REGISTRAR'S SIGNATURE Blanch Bowser							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 1 1957

RECEIVED

07955

CERTIFICATE OF DEATH

07928

Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md. R.F.D.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md. Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS (Conococheague Park)	
3. NAME OF DECEASED (Type or print) First Middle Last Della M Mc Kinzie		4. DATE OF DEATH Month Day Year 7 15 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1876
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 19 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Cearfoss, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Souders		14. MOTHER'S MAIDEN NAME Charlotte Stoner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec. 27 , 19 56 , to July 15 , 19 57 , that I last saw the deceased alive on July 12 , 19 57 , and that death occurred at 9:30 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Archie Robert Cohen</i> M.D.		PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 7-18-57	22c. NAME OF CEMETERY OR CREMATORY Rose Hill
22d. LOCATION (City, town, or county) (State) Hagerstown Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR DATE July 19-57		24b. REGISTRAR'S SIGNATURE <i>Leroy M. Feller</i> <i>(Deputy)</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased HARRISON, M. B. S.		Place of Birth Washington	
Date of Birth (Month, Day, Year)		Date of Death (Month, Day, Year)	
Sex Male		Race White	
Usual Residence Baltimore, Md.		Place of Death Baltimore, Md.	
Cause of Death (List in order of sequence)		Manner of Death (Natural, Accidental, Suicide, Homicide, Undetermined)	
1. (Immediate Cause)		1. (Immediate Cause)	
2. (Intermediate Cause)		2. (Intermediate Cause)	
3. (Underlying Cause)		3. (Underlying Cause)	
4. (Contributing Cause)		4. (Contributing Cause)	
5. (Cause of Death)		5. (Cause of Death)	
6. (Cause of Death)		6. (Cause of Death)	
7. (Cause of Death)		7. (Cause of Death)	
8. (Cause of Death)		8. (Cause of Death)	
9. (Cause of Death)		9. (Cause of Death)	
10. (Cause of Death)		10. (Cause of Death)	
11. (Cause of Death)		11. (Cause of Death)	
12. (Cause of Death)		12. (Cause of Death)	
13. (Cause of Death)		13. (Cause of Death)	
14. (Cause of Death)		14. (Cause of Death)	
15. (Cause of Death)		15. (Cause of Death)	
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19. (Cause of Death)		19. (Cause of Death)	
20. (Cause of Death)		20. (Cause of Death)	
21. (Cause of Death)		21. (Cause of Death)	
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91. (Cause of Death)		91. (Cause of Death)	
92. (Cause of Death)		92. (Cause of Death)	
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BUREAU V. S.

JUL 23 1957

RECEIVED

BUREAU V. S.

JUL 29 1957

RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07918

CERTIFICATE OF DEATH

07930

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 22 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital		d. STREET ADDRESS 1 113 Summer St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Luther James Moats, Sr.		4. DATE OF DEATH Month Day Year July 10 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 26, 1893
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months 1 Days 24	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) custodian		10b. KIND OF BUSINESS OR INDUSTRY Newspaper	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Henry P. Moats		14. MOTHER'S MAIDEN NAME Susan Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-09-2545	
17. INFORMANT Address Mrs. Anna May Moats, Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162X Branchiogenic carcinoma with DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) wide spread metastases DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 18 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0 General arterio sclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 1, 1956, to July 10, 1957, that I last saw the deceased alive on July 10, 1957, and that death occurred at 11:00 M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Edward W. Dittmann M.D. 217 W. Washington St. 7/12/57			
PHYSICIAN'S NAME (Type) Edward W. Dittmann Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-13-57	
22c. NAME OF CEMETERY OR CREMATORY Manor Cemetery		22d. LOCATION (City, town, or county) (State) Near Tilghmington, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	
Edith V. Lea Williamsport		July 15, 1957	

BUREAU V. S.

1957 17 JUL

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07919

CERTIFICATE OF DEATH

08943

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON HAGERSTOWN		c. LENGTH OF STAY IN 1b 40 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 832 S. POTOMAC ST.		d. STREET ADDRESS 832 S. POTOMAC ST.	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM LANE MOORE		4. DATE OF DEATH Month Day Year JULY 22 19 57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/14/1910
9. AGE (In years last birthday) 47		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OFFICE CLERK		10b. KIND OF BUSINESS OR INDUSTRY AIRCRAFT CO.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL M. MOORE		14. MOTHER'S MAIDEN NAME MARY ELIZABETH HARSHMAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. W.W.#2 217-10-2938	
17. INFORMANT MRS. HALLIE S. MOORE		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4222 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Myocarditis (c) None		INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 16, 1957 to July 22, 1957 that I last saw the deceased alive on July 22, 1957 , and that death occurred at 2:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. J. Beasley M.D.		DATE SIGNED 7/22/57	
PHYSICIAN'S NAME (Type) Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 7/24/57	22c. NAME OF CEMETERY OR CREMATORY FAIRFIELD UNION CEM.	22d. LOCATION (City, town, or county) (State) FAIRFIELD PENNA.
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Normant ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR Aug. 16, 1957	24b. REGISTRAR'S SIGNATURE Paul H. Bowers

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

NAME OF DECEASED		DATE OF DEATH	
JAMES E. MOORE		JULY 10, 1957	
AGE		SEX	
45		Male	
RACE		RELIGION	
White		Roman Catholic	
BIRTHPLACE		PLACE OF BIRTH	
Baltimore, Md.		Baltimore, Md.	
MARRIAGE		MANNER OF DEATH	
Married		Natural Causes	
OCCUPATION		CAUSE OF DEATH	
Carpenter		Heart Disease	
EDUCATION		IMMEDIATE CAUSE	
High School		Coronary Thrombosis	
PREVIOUS ILLNESS		INTERVIEWED	
None		Yes	
DATE OF INTERVIEW		SIGNATURE OF PHYSICIAN	
July 10, 1957		[Signature]	
DATE OF CERTIFICATE		DATE OF BURIAL	
July 10, 1957		July 10, 1957	
PLACE OF BURIAL		NAME OF FUNERAL HOME	
St. Mary's Cemetery		[Name]	
NAME OF NEXT OF KIN		NAME OF MINISTER	
Mrs. Hattie E. Moore		[Name]	
ADDRESS		CITY	
[Address]		Baltimore, Md.	
STATE		COUNTY	
Maryland		Baltimore	

BUREAU V. 2

AUG 20 1957

RECEIVED

67920

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 12 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
4. DATE OF DEATH First Middle Last GEORGE B. MULLENDORE				5. DATE OF DEATH Month Day Year JULY 16 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUGUST 14 1870	
9. AGE (In years last birthday) 86 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER		11. BIRTHPLACE (State or foreign country) GAPLAND WASH.CO.MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DANIEL MULLENDORE				14. MOTHER'S MAIDEN NAME MARY BEACHLEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NONE		17. INFORMANT Address CARROLL T. MULLENDORE ROHRERSVILLE MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Virus Pneumonia 492X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombus of right & left common iliac DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 466X						INTERVAL BETWEEN ONSET AND DEATH 12 days 2 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 9		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 3 , 19 57 , to July 16 , 19 57 , that I last saw the deceased alive on July 15 , 19 57 , and that death occurred at 2:15 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE G. W. Heelan				DATE SIGNED 7/16/57			
PHYSICIAN'S NAME (Type) G. W. Heelan				ADDRESS (Street, city or town, state) Boonsboro, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JULY 18 1957		22c. NAME OF CEMETERY OR CREMATORY ROHRERSVILLE CEMETERY		22d. LOCATION (City, town, or county) (State) ROHRERSVILLE MD.	
23. FUNERAL DIRECTOR'S SIGNATURE East Funeral Home				24. REC'D BY REGISTRAR Boonsboro Md. July 20, 1957			
25. REGISTRAR'S SIGNATURE Boonsboro				26. REGISTRAR'S SIGNATURE Boonsboro			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]		4. DATE OF BIRTH [Illegible]		5. PLACE OF BIRTH [Illegible]		6. STATE OF BIRTH [Illegible]	
7. OCCUPATION [Illegible]		8. MARITAL STATUS [Illegible]		9. COLOR [Illegible]		10. RELIGION [Illegible]		11. EDUCATION [Illegible]		12. SOCIAL CLASS [Illegible]	
13. CAUSE OF DEATH [Illegible]		14. MANNER OF DEATH [Illegible]		15. PLACE OF DEATH [Illegible]		16. DATE OF DEATH [Illegible]		17. TIME OF DEATH [Illegible]		18. SIGNATURE OF DECEASED [Illegible]	
19. SIGNATURE OF PHYSICIAN [Illegible]		20. SIGNATURE OF CORONER [Illegible]		21. SIGNATURE OF JURY [Illegible]		22. SIGNATURE OF WITNESSES [Illegible]		23. SIGNATURE OF DECEASED [Illegible]		24. SIGNATURE OF DECEASED [Illegible]	

RECEIVED
JUL 23 1957
BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07921

CERTIFICATE OF DEATH

Reg. Dist. No.

07932

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>2 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LENA</u> Middle <u>ELLEN</u> Last <u>MUNDEY</u>				4. DATE OF DEATH Month <u>July</u> Day <u>17</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 11, 1915</u>	9. AGE (In years last birthday) <u>42</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>6</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington Co. Maryland</u>	
13. FATHER'S NAME <u>Albert Mills</u>				14. MOTHER'S MAIDEN NAME <u>Lizzie Nanemaker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>none</u>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Charlotte Hasenbuhler Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>CARDIOVASCULAR COLLAPSE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cirrhosis Liver and</u> (c) <u>Arteriosclerotic heart disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>581.0</u> <u>none except stroke</u>				INTERVAL BETWEEN ONSET AND DEATH <u>min</u> <u>hrs.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7-17</u> , 19 <u>55</u> , to <u>7-17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7-17</u> , 19 <u>57</u> , and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Louis E. Graft M.D.</u>				ADDRESS (Street, city or town, state) <u>119 E. Antietam</u> DATE SIGNED <u>7-19-57</u>			
PHYSICIAN'S NAME (Type) <u>Louis E. Graft M.D.</u>				<u>Hagerstown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/20/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. F. Funcher, Mayor</u>				ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>July 20, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Blair Flowers</u>			

BUREAU V. S.

JUL 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07922

CERTIFICATE OF DEATH

Reg. Dist. No.

07933
382

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. County Hospital				e. STREET ADDRESS 1126 Virginia Ave			
3. NAME OF DECEASED (Type or print) First IDA Middle SOPHIA Last NORRIS				4. DATE OF DEATH Month July Day 5 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 30 1877	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George N. Keplinger				14. MOTHER'S MAIDEN NAME Sabina A. Palmer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs Betty Leigh 3 St Albans Drive			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 6 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/3/57 to 7/6/57 , that I last saw the deceased alive on 7/5/57 , and that death occurred at 135th St. M, from the causes and on the date stated above. ADDRESS (Street, city or town, State) DATE SIGNED 7/6/57							
ACTUAL SIGNATURE [Signature]		M.D. 135th St.					
PHYSICIAN'S NAME (Type) [Signature]							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/8/57		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown Md.		24. REC'D BY REGISTRAR July 8, 1957	
				24b. REGISTRAR'S SIGNATURE [Signature]			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

1957

1125 Virginia Ave

Wash. County Hospital

July 5 1957

MALE

WHITE

100

1125 Virginia Ave

Wash. County Hospital

1125 Virginia Ave

Wash. County Hospital

1125 Virginia Ave

1125 Virginia Ave

Wash. County Hospital

BUREAU V. 2

JUL 10 1957

RECEIVED

07923

CERTIFICATE OF DEATH

07934

Reg. Dist. No.

302

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 60 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				d. STREET ADDRESS 1102 S. POTOMAC ST.			
3. NAME OF DECEASED (Type or print) First FOLLMER Middle DELL Last PALMER				4. DATE OF DEATH Month JULY Day 26 Year 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/23/1872	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CABINET MAKER FURNITURE CO.				10b. KIND OF BUSINESS OR INDUSTRY PENNSYLVANIA		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JAMES R. PALMER				14. MOTHER'S MAIDEN NAME MARY E. BRUCH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 214-09-1863		17. INFORMANT MRS. ANICE MILLER Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hyponephrosis. Bilat 601X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prostatic Hypertrophy DUE TO (c) Atherosclerosis INTERVAL BETWEEN ONSET AND DEATH ? 20 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 5/22/51 , 19 51 , to July 26th , 19 57 , that I last saw the deceased alive on July 26th , 19 57 , and that death occurred at 2:10 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 159 W. Washington St., Hagerstown, Md. DATE SIGNED 7/27/57							
ACTUAL SIGNATURE Philip J. Hirshman				PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 7/29/57		22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.	
22d. LOCATION (City, town, or county) HAGERSTOWN				22e. (State) MD.			
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment, Hagerstown, Md				ADDRESS Hagerstown, Md		24. REC'D BY REGISTRAR July 29, 1957	
24b. REGISTRAR'S SIGNATURE Robert Bowers							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 31 1957

RECEIVED

07924

CERTIFICATE OF DEATH

Reg. Dist. No.

07936

382

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 7 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BEAVER CREEK RURAL d. STREET ADDRESS HAGERSTOWN MARYLAND ROUTE 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ABNER RANDALL PAULSGROVE				4. DATE OF DEATH Month Day Year JULY 4 1957 19			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCTOBER 2 1898	
9. AGE (In years last birthday) 58 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER		10b. KIND OF BUSINESS OR INDUSTRY OWN FARM		11. BIRTHPLACE (State or foreign country) BEAVER CREEK WASH.CO.MD. U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME CHRISTIAN PAULSGROVE			
14. MOTHER'S MAIDEN NAME HANNAH FREY				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) - NO -			
16. SOCIAL SECURITY NO. 215 20 9505				17. INFORMANT MRS. SARAH PAULSGROVE HAGERSTOWN MD. R 1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute intestinal obstruction 160X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Probable Metastatic Carcinoma - DUE TO (c) primary site left Maxillary Sinus INTERVAL BETWEEN ONSET AND DEATH 12 days 2 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0 generalized arteriosclerosis							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr 3, 1956 , to July 4, 1957 , that I lost saw the deceased olive on July 4, 1957 , and that death occurred at 4 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Edward W. Ditto III M.D. 217 W. Washington St. 7/6/57 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Edward W. Ditto III, M.D. Hagerstown, Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JULY 7 1957		22c. NAME OF CEMETERY OR CREMATORY BEAVER CREEK CEMETERY		22d. LOCATION (City, town, or county) (State) BEAVER CREEK WASH.CO.MD	
23. FUNERAL DIRECTOR'S SIGNATURE BAST FUNERAL HOME				23b. REC'D BY REGISTRAR July 9, 1957		24. REGISTRAR'S SIGNATURE Phyllis Bowers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07925

CERTIFICATE OF DEATH

07937

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MATYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b LIFE			
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				d. STREET ADDRESS 916 ST. CLAIR			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First CARL Middle JEFFREY Last PETERSON				4. DATE OF DEATH Month JULY Day 20 Year 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/19/57	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME DOUGLAS H.M. PETERSON				14. MOTHER'S MAIDEN NAME WANDA Y. HOMES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. NONE		17. INFORMANT MR. DOUGLAS PETERSON Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776x Paem. tu. t. y. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 10 1/2 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 19, 1957 , to July 20, 1957 that I last saw the deceased alive on July 19, 1957 , and that death occurred at 9A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE H. Edwin Blair				ADDRESS (Street, city or town, state) 214 N. Potomac St. Hagerstown, Md. DATE SIGNED 7/22/57			
PHYSICIAN'S NAME (Type) H. Edwin Blair, M. D.				214 North Potomac Street, Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/22/57		22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment				ADDRESS Hagerstown, Md.		24. REC'D BY REGISTRAR July 24, 1957 24b. REGISTRAR'S SIGNATURE W. J. Norment	

CERTIFICATE OF DEATH

NAME OF DECEASED WASHINGTON		AGE 10		SEX M		RACE W		DATE OF BIRTH 1947		PLACE OF BIRTH BALTIMORE	
OCCUPATION STUDENT		EDUCATION HIGH SCHOOL		MARRIAGE SINGLE		RELIGION METHODIST		MARITAL STATUS SINGLE		DATE OF MARRIAGE	
CAUSE OF DEATH HEART DISEASE		IMMEDIATE CAUSE CORONARY THROMBOSIS		INTERMEDIATE CAUSE HYPERTENSION		UNDERLYING CAUSE ARTERIOSCLEROSIS		MANNER OF DEATH NATURAL		PLACE OF DEATH HOSPITAL	
DATE OF DEATH JULY 26, 1957		TIME OF DEATH 10:00 AM		PLACE OF DEATH HOSPITAL		NAME OF PHYSICIAN DR. J. H. SMITH		NAME OF NURSE MISS J. BROWN		NAME OF ATTENDING PHYSICIAN DR. J. H. SMITH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF NURSE		SIGNATURE OF ATTENDING PHYSICIAN		SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF REGISTRAR	

BUREAU V. 3

JUL 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07926

CERTIFICATE OF DEATH

07938

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b LIFE	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN		d. STREET ADDRESS RT. #1 HAGERSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last BRUCE THERON RINEHART		4. DATE OF DEATH Month Day Year JULY 18 19 57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9/5/1902
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN		10b. KIND OF BUSINESS OR INDUSTRY MACHINE SHOP	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES HENRY RINEHART		14. MOTHER'S MAIDEN NAME LEONA WOLFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-09-6041	
17. INFORMANT MR. THERON RINEHART		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infraction 260X DUE TO Acute myocardial failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Severe Diabetes M DUE TO Atrophy of pancreas (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1		INTERVAL BETWEEN ONSET AND DEATH 45 days 21 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour o. m. none 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) - - -	
21. I certify that I attended the deceased from July 1954 , to July 18 1957 , that I last saw the deceased alive on July 17 1957 , and that death occurred at 12:15AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 115 N. Potomac Street 7-20-57			
ACTUAL SIGNATURE S. Robert Wells		M.D. 115 N. Potomac Street	
PHYSICIAN'S NAME (Type) S. Robert Wells, M.D.		Hagerstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 7/20/57	22c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.	22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Normant, Hagerstown, Md.		24. REC'D BY REGISTRAR July 22, 1957	
24b. REGISTRAR'S SIGNATURE Phas H. Powers			

RECEIVED

JUL 24 1957

BUREAU V. 1

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1957

1. NAME OF DECEASED

WASHINGTON

MARYLAND

WASHINGTON

WASHINGTON

2. SEX

MALE

MALE

3. AGE

BRUCE

THOMAS

THOMAS

THOMAS

4. RACE

WHITE

WHITE

WHITE

5. OCCUPATION

CHARLES HENRY BISHOP

CHARLES HENRY BISHOP

6. DATE OF DEATH

1957

1957

1957

7. PLACE OF DEATH

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

8. CAUSE OF DEATH

1957

1957

1957

1957

1957

1957

1957

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07927

CERTIFICATE OF DEATH

07939

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
c. LENGTH OF STAY IN 1b <u>30 Minutes</u>				d. STREET ADDRESS <u>17 Public Square</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>He Rena A. Ross</u>				4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 13, 1876</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Near Waynesboro Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Geo. M. Pryor</u>		14. MOTHER'S MAIDEN NAME <u>Laura Harbaugh</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. David Baughman, Hagerstown Md., #3</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Arteriosclerosis - general</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>5 yrs.</u> <u>yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1946 to July 4, 1957</u> , that I last saw the deceased alive on <u>July 4, 1957</u> , and that death occurred at <u>1 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2144 Potomac St, Hagerstown, Md.</u> DATE SIGNED <u>md</u>							
ACTUAL SIGNATURE <u>Clayd A. Hoffman</u>		M.D. <u>2144 Potomac St, Hagerstown, Md.</u>		PHYSICIAN'S NAME (Type) <u>Clayd A. Hoffman</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Waynesboro, Franklin Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Z. Gore</u>		ADDRESS <u>Waynesboro, Pa.</u>		24a. REC'D BY REGISTRAR <u>July 8, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Shasth Bowers</u>	

07928

CERTIFICATE OF DEATH

07940

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 3 WEEKS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN			
f. STREET ADDRESS 2208 VIRGINIA AVENUE				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ANNA Middle MAE Last ROUTZAHN				4. DATE OF DEATH Month JULY Day 27 Year 1957			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 12 1874 82 yrs.	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months 28 Days 04 Hours 00 Min.	IF UNDER 24 HRS. Hours 00 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) BOONSBORO WASH.CO.MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.E.							
13. FATHER'S NAME JOHN HUNTZBERRY				14. MOTHER'S MAIDEN NAME ANNA McALLISTER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. NONE		17. INFORMANT CHARLES V. ROUTZAHN HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Virus Pneumonia 492x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH 28 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x Diabetes Mellitus				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from June 11, 1956 to July 27, 1957 , that I last saw the deceased alive on July 27, 1956 , and that death occurred at 6:15 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 214 N. Pot. St. - Hagerstown, Md.				DATE SIGNED July 31, 1957			
ACTUAL SIGNATURE Lloyd A. Hoffmar							
PHYSICIAN'S NAME (Type) Lloyd A. Hoffmar							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JULY 30 1957		22c. NAME OF CEMETERY OR CREMATORY BOONSBORO CEMETERY		22d. LOCATION (City, town, or county) (State) BOONSBORO WASH.CO.MD.	
23. FUNERAL DIRECTOR'S SIGNATURE East End Home Boonsboro Wash. Co. Md.				24a. REC'D BY REGISTRAR July 31, 1957		24b. REGISTRAR'S SIGNATURE Charles E. Cowers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar.

RECEIVED
AUG 1 1957
BUREAU V. S.

BUREAU V. S.

AUG 1 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07929

CERTIFICATE OF DEATH

07941

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Rural-Pinesburg Williamsport	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital		d. STREET ADDRESS /	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Etha May Shank		4. DATE OF DEATH Month Day Year July 20 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 18, 1891
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 4 Days 2	
IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY county office	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John D. Shank		14. MOTHER'S MAIDEN NAME Cora Gossard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-01-8539	
17. INFORMANT Mr. George L. Shank, Pinesburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Central Nervous Chage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 Day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1957 to 1957, that I last saw the deceased alive on 1957, and that death occurred at 2:30 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Ralph Leysung M.D.		PHYSICIAN'S NAME (Type) Williamsport Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-23-57	
22c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery		22d. LOCATION (City, town, or county) (State) Near Clearspring, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Wolf Williamsport Md		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	

BUREAU V. S.

JUL 26 1957

RECEIVED

Item 8 Film 6218 8-6-57 et
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
07930
CERTIFICATE OF DEATH

07942

Reg. Dist. No. **302**

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penna b. COUNTY Franklin			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greencastle			
c. LENGTH OF STAY in 1b 4 mos.				d. STREET ADDRESS 233 E. Grant St.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garlock Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ruth Middle E. Last Shipp				4. DATE OF DEATH Month July Day 29 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 2, 1896	
9. AGE (In years last birthday) 60 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY House work		11. BIRTHPLACE (State or foreign country) Franklin Co Penna	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Cyrus Rock			
14. MOTHER'S MAIDEN NAME Mary Ellen Miller				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. None				17. INFORMANT Mr. Clyde Shipp, Greencastle, Pa			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Aneurysm 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) with mitral stenosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from June 20, 1956 , to July 29, 1957 , that I last saw the deceased alive on May 19, 1957 , and that death occurred at 9:00 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE David R. Hess M.D.				ADDRESS (Street, city or town, state) Shady Grove, Pa.			
DATE SIGNED 7/30/57				PHYSICIAN'S NAME (Type) David R. Hess M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/1/1957		22c. NAME OF CEMETERY OR CREMATORY Browns Mill Cemetery		22d. LOCATION (City, town, or county) (State) Antietam Twp Franklin Co Penna	
23. FUNERAL DIRECTOR'S SIGNATURE Harold M. Zimmerman				ADDRESS Greencastle, Pa		24. REC'D BY REGISTRAR July 31, 1957	
24b. REGISTRAR'S SIGNATURE Frank H. Bowers							

BUREAU V. S.

AUG 1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07943

Reg. Dist. No.

302

C7931

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 18 hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS 431 Salem Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bertha Middle Lee Last Shry				4. DATE OF DEATH Month July Day 19 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 19, 1882		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months 74 Days 19 Hours 57	IF UNDER 24 HRS. Hours 57 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Va Waterford, Montgomery Co.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Lewis				14. MOTHER'S MAIDEN NAME Mary Fry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) - none		17. INFORMANT Address Violet Ensminger -431 Salem Ave- Hagerstown, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Expired while under Na Pentothal anesthesia 420-1 DUE TO advanced generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic coronary heart disease DUE TO coronary Occlusion (old) (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Month, Day, Year Hour a. m. None p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) - - -	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>S. Robert Wells</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) S. Robert Wells, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-22-57		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Wash Co Md	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				24a. REC'D BY REGISTRAR July 23, 1957			
				24b. REGISTRAR'S SIGNATURE <i>W. H. Bowers</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the register prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Time of Death		Place of Death		Cause of Death		Manner of Death		Signature of Examiner		Signature of Coroner	
John Doe		35		Male		White		July 24, 1957		10:00 AM		Home		Heart Disease		Natural		[Signature]		[Signature]	
Occupation		Education		Marital Status		Previous Illnesses		Alcohol Consumption		Tobacco Use		Drugs		Injury		Suicide		Other		Remarks	
Teacher		High School		Married		None		Occasional		Daily		None		None		None		None		None	

BUREAU V. 1

JUL 24 1957

RECEIVED

07932

CERTIFICATE OF DEATH

Reg. Dist. No.

07944
302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 38 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 219 N. Cleveland Ave.				d. STREET ADDRESS 219 N. Cleveland Ave.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William H Shupp				4. DATE OF DEATH Month 7 Day 26 Year 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 10, 1876	
9. AGE (In years lost birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired				10b. KIND OF BUSINESS OR INDUSTRY Priors		11. BIRTHPLACE (State or foreign country) Charlton, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Daniel Shupp				14. MOTHER'S MAIDEN NAME Ann S. Weller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-24-3130		17. INFORMANT Mrs. Bertha Shupp Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Atherosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) with cardiac decompensation DUE TO (c) General arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 6 mo 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 610X Benign Prostatic hypertrophy						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1957 , to July 26, 1957 , that I last saw the deceased alive on July 21, 1957 , and that death occurred at 8:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 217 W. Washington St. Hagerstown, Md. DATE SIGNED 7/27/57							
ACTUAL SIGNATURE Edward W. Ditto III				M.D. 217 W. Washington St.			
PHYSICIAN'S NAME (Type) Edward W. Ditto III, M.D.				217 W. Washington St. Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 7-29-57		22c. NAME OF CEMETERY OR CREMATORY Rest Haven		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss Hagerstown, Md.				ADDRESS		24. REC'D BY REGISTRAR July 30, 1957	
				24b. REGISTRAR'S SIGNATURE Phas H. Bowers			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
Daniel Shupp		38 yrs		M		W		Nov. 10, 1957		Baltimore, Md.	
Married		Single		H		W		50		50	
Cause of Death		Manner of Death		Occupation		Education		Religion		Usual Residence	
Heart Disease		Natural		Shupp		High School		Catholic		Baltimore, Md.	
Date of Birth		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Disposition	
1919-11-10		1957-11-10		1957-11-10		1957-11-10		1957-11-10		1957-11-10	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Pathologist		Signature of Forensic Examiner	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

AUG 1 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07933

CERTIFICATE OF DEATH

07945

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 10 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 713 Marshall st				d. STREET ADDRESS 713 Marshall st		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last LOUISA WILES SPRANKLE				4. DATE OF DEATH Month Day Year July 13 1957 19			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 9 1864	
9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Hagerstown Wash, Co		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Wiles				14. MOTHER'S MAIDEN NAME Louisa Wiles			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Address Margie Dawson 711 Marshall st Hagerstown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3 July , 19 57 , to 13 July , 19 57 , that I last saw the deceased alive on 12 July , 19 57 , and that death occurred at 10:45 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 5 Eden St Hagerstown Md. 7/15							
ACTUAL SIGNATURE Eden St Hagerstown Md.							
PHYSICIAN'S NAME (Type) Eden St Hagerstown Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/16/57		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.				24. REC'D BY REGISTRAR July 17, 1957		24b. REGISTRAR'S SIGNATURE Shirley Bowers	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 6218 7-29-57 et

C7934

CERTIFICATE OF DEATH

Reg. Dist. No.

07946
302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown, Md</u>				c. LENGTH OF STAY IN 1b <u>50yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Maryland</u> 03	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>658 Pennsylvania Ave</u>				d. STREET ADDRESS <u>658 Pennsylvania ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Ralph</u> Middle <u>Stewart</u> Last				4. DATE OF DEATH Month <u>7</u> Day <u>18</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 20 1890</u>	
9. AGE (In years last birthday) <u>66 07</u> yrs.		IF UNDER 1 YEAR Months <u>07</u> Days <u>07</u> Hours <u>07</u> Min.		IF UNDER 24 HRS. Months <u>07</u> Days <u>07</u> Hours <u>07</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lubrication</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>W.M. Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Keedville, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>							
13. FATHER'S NAME <u>David Stewart</u>				14. MOTHER'S MAIDEN NAME <u>Anna Lawry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>319-05-2048</u>			
17. INFORMANT <u>Mrs. Annie Freeman</u>				18. ADDRESS <u>1020 W. 43rd Street Baltimore 11, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma - Colon</u> <u>153X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>153X</u> DUE TO (c) <u>153X</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 11</u> , 19 <u>38</u> , to <u>July 18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 18</u> , 19 <u>57</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>159 W. Washington St. Hagerstown Md</u> DATE SIGNED <u>7/20/57</u>							
ACTUAL SIGNATURE <u>Philip J. Hirshman</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Philip J. Hirshman, M.D. 159 W. Washington St., Hagerstown, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-21-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John R Watson Jr. Hagerstown Md</u>				ADDRESS <u>Hagerstown Md</u>		24a. REC'D BY REGISTRAR <u>July 22, 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Blair H. Rogers</u>							

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY		HISTORICAL RECORD	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF BURIAL		SIGNATURE OF RECORDS	

BUREAU V. S.

JUL 24 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07935

CERTIFICATE OF DEATH

07947

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1213 Crescent Road				d. STREET ADDRESS 1213 Crescent Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First CARL Middle V Last TAYLOR				4. DATE OF DEATH Month July Day 25 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 1, 1894	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Firemen				10b. KIND OF BUSINESS OR INDUSTRY W.Md.R.R.		11. BIRTHPLACE (State or foreign country) Washington County, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Allen S. Taylor				14. MOTHER'S MAIDEN NAME Martha Trone			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W. 1				16. SOCIAL SECURITY NO. 214-09-0961			
17. INFORMANT Mrs. Leona Thomas Taylor				Address 1213 Crescent Road Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis of coronaries (c) 20 yrs							INTERVAL BETWEEN ONSET AND DEATH sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on 7/25/57 , 19____, and that death occurred at 8:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 136 North Potomac St. Hagerstown, Maryland DATE SIGNED 7/26/57							
ACTUAL SIGNATURE Howard N. Weeks				M.D. 136 North Potomac St. Hagerstown, Maryland			
PHYSICIAN'S NAME (Type) HOWARD N. WEEKS, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/28/57		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.				24. REC'D BY REGISTRAR July 27, 1957		25. REGISTRAR'S SIGNATURE Blair H. Brown	

MEDICAL CERTIFICATION

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VS

Wm. A. Hart - J. Pres

BUREAU V. S.

JUL 30 1957

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BOOKED

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07936

CERTIFICATE OF DEATH

Reg. Dist. No. 302

07948

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown</u> X O			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>Huyetts Cross Roads</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>LOUISE</u> Last <u>TRUMPOWER</u>				4. DATE OF DEATH Month <u>July</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 17, 1891</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>29</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Washington County, Maryland</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Lewis Dougherty</u>				14. MOTHER'S MAIDEN NAME <u>Laura Mae Shank</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT <u>Mr. Clarence V. Trumpower</u>				Address <u>Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pancytopenia - cause unknown</u> <u>463X</u> DUE TO <u>Pneumonitis of lungs; Pericarditis; myocarditis; Coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Phlebitis of great saphenous veins and deep femoral veins (rt & lt)</u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 mos ?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>None</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>				20f. (City or town) (County) (State) <u>- - -</u>			
21. I certify that I attended the deceased from <u>May 27</u> , 19 <u>57</u> , to <u>June 16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 16</u> , 19 <u>57</u> , and that death occurred at <u>1:25 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. Robert Wells</u>				ADDRESS (Street, city or town, state) <u>115 N. Potomac Street</u>			
PHYSICIAN'S NAME (Type) <u>S. Robert Wells, M.D.</u>				DATE SIGNED <u>7-17-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>7/19/1957</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>St. Paul's, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Boyer</u>				ADDRESS <u>Hagerstown, Maryland</u>			
24a. REC'D BY REGISTRAR <u>July 20, 1957</u>				24b. REGISTRAR'S SIGNATURE <u>Thomas H. Bowers</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		35		M		W		1928		MEMPHIS		TENNESSEE		U.S.A.		U.S.A.	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		PERIOD OF ILLNESS		TREATMENT		HISTORY		REMARKS	
JULY 6, 1968		MEMPHIS, TENNESSEE		SHOOTING		HOMICIDE		FIREARM		10 DAYS		HOSPITAL		NO		FUGITIVE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK		SIGNATURE OF CHURCH		SIGNATURE OF FUNERAL HOME		SIGNATURE OF BURIAL	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

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JUL 23 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07957

CERTIFICATE OF DEATH

07949

Reg. Dist. No.

803

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BIG POOLE				c. LENGTH OF STAY IN 1b 8 YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) SHANKTOWN ROAD				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES MILTON TWIGG				4. DATE OF DEATH Month Day Year 7 30 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 1, 1874	
9. AGE (In years last birthday) 83 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR		10b. KIND OF BUSINESS OR INDUSTRY FARM		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JACOB TWIGG		14. MOTHER'S MAIDEN NAME LOUISE HARWOOD		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO	
16. SOCIAL SECURITY NO. 232-26-3891		17. INFORMANT MRS. MARIE J. TWIGG		Address BIG POOLE, MD.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic myocardial heart disease 422.1 DUE TO Myocardial heart failure - grade iv Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Hour a. m. p. m. none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) - - -	
21. I certify that I attended the deceased from May , 19 57 , to July 30 , 19 57 , that I last saw the deceased alive on July 24 , 19 57 , and that death occurred at 7:45 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE S. Robert Wells		M.D. 115 N. Potomac Street		DATE SIGNED 8-1-57		ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type) S. Robert Wells, M.D.		Hagerstown, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Aug. 3, 1957		22c. NAME OF CEMETERY OR CREMATORY TWIGG CEMETERY		22d. LOCATION (City, town, or county) (State) FLINTSTONE, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John F. Clark		ADDRESS Clear Spring, Md.		24a. REC'D BY REGISTRAR Aug 3-57		24b. REGISTRAR'S SIGNATURE Joseph W. Murray	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. DATE OF DEATH		7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF DECEASED		12. SIGNATURE OF WITNESSES		13. SIGNATURE OF FUNERAL HOME		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF MENTAL HEALTH PROFESSIONAL		16. SIGNATURE OF OTHER		17. SIGNATURE OF OTHER		18. SIGNATURE OF OTHER		19. SIGNATURE OF OTHER		20. SIGNATURE OF OTHER		21. SIGNATURE OF OTHER		22. SIGNATURE OF OTHER		23. SIGNATURE OF OTHER		24. SIGNATURE OF OTHER		25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER		28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER		31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER		34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER		37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER		40. SIGNATURE OF OTHER		41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER		43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER		46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER		49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER		51. SIGNATURE OF OTHER		52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER		55. SIGNATURE OF OTHER		56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER		58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER		61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER		64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER		67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER		70. SIGNATURE OF OTHER		71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER		73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER		76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER		79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER		81. SIGNATURE OF OTHER		82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER		85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER		88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER		91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER		93. SIGNATURE OF OTHER		94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER		97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER		100. SIGNATURE OF OTHER	
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BUREAU V. S.

MAY 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07950
302
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 19 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport, Md.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Co. Hospital				d. STREET ADDRESS 132 N. Conococheague St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Terry Middle Ann Last Tyler				4. DATE OF DEATH Month July Day 10 Year 19 57				
5. SEX Female		6. COLOR OR RACE colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 21, 1957		
9. AGE (In years last birthday) yrs. 19		IF UNDER 1 YEAR Months 09		IF UNDER 24 HRS. Hours 19 Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none			10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lee Robinson				14. MOTHER'S MAIDEN NAME Doris Lorrain Tyler				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Doris L. Tyler, Williamsport, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aspirin DUE TO Aspirin (c) Aspirin							INTERVAL BETWEEN ONSET AND DEATH 19 Days 1 Day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE D. B. Young M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF 7-11-57		22c. NAME OF CEMETERY OR CREMATORY Riverview		22d. LOCATION (City, town, or county) (State) Williamsport, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Edith V. Leaf-Williamsport				ADDRESS Williamsport, Md.		24a. REC'D BY REGISTRAR July 12, 1957		
				24b. REGISTRAR'S SIGNATURE Frank Bowers				

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

From
1. 2. 3.

BUREAU V. S.

JUL 15 1957

RECEIVED

CERTIFICATE OF DEATH

07951

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Pennsylvania</u> b. COUNTY <u>Franklin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>4 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Martin Manor Convalescent Home</u>				d. STREET ADDRESS <u>633 Philadelphia Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Rose Belle Tyler</u>				4. DATE OF DEATH Month Day Year <u>July 9 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 5, 1864</u>	9. AGE (In years lost birthday) <u>93</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>4</u>	IF UNDER 24 HRS. Hours <u>4</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Millerstown, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John H. G. Kinter</u>				14. MOTHER'S MAIDEN NAME <u>Ann Eliza Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>William L. Kinter Chambersburg, Pennsylvania</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>generalized arteriosclerosis with</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral thrombosis</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0 Bilateral cataracts</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept. 17, 1956</u> to <u>July 9, 1957</u> , that I last saw the deceased alive on <u>July 9, 1957</u> , and that death occurred at <u>11:45</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward W. Ditto III</u> M.D. <u>217 W. Washington St.</u>				DATE SIGNED <u>7/10/57</u>			
PHYSICIAN'S NAME (Type) <u>Edward W. Ditto III, M.D.</u> <u>217 W. Washington St. Hagerstown, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/12/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Grove Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Chambersburg, Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Rye</u>				ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>July 12, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Thos. H. Gower</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>		<p>3. AGE [Faint text]</p>	
<p>4. DATE OF DEATH [Faint text]</p>		<p>5. TIME OF DEATH [Faint text]</p>		<p>6. PLACE OF DEATH [Faint text]</p>	
<p>7. CAUSE OF DEATH [Faint text]</p>		<p>8. MANNER OF DEATH [Faint text]</p>		<p>9. SIGNATURE OF PHYSICIAN [Faint text]</p>	
<p>10. SIGNATURE OF REGISTRAR [Faint text]</p>		<p>11. SIGNATURE OF DECEASED [Faint text]</p>		<p>12. SIGNATURE OF WITNESSES [Faint text]</p>	

BUREAU V. 2

JUL 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr. W. T. Layman

07952

CERTIFICATE OF DEATH

Reg. Dist. No. 302

07939

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 6 Weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jackson conv. Home				e. STREET ADDRESS 817 Forest drive			
3. NAME OF DECEASED (Type or print) First PRUDENCE Middle ANN Last WAGAMAN				4. DATE OF DEATH Month July Day 7 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 4 1864	9. AGE (In years last birthday) 92 yrs.	IF UNDER 1 YEAR Months 92	IF UNDER 24 HRS. Days 92 Hours 92 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Md. Sharpsburg Wash. Co		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Aaron Frey				14. MOTHER'S MAIDEN NAME Barbara Morrow			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs Margaret Harris 817 Forest Drive Hagerstown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease DUE TO 10 months certain (c) 10 months certain							INTERVAL BETWEEN ONSET AND DEATH 6 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 443.8 Auricular Fibrillation; Congestive Heart Failure							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from Sept. 6, 1956 , to July 7, 1957 , that I last saw the deceased alive on June 29, 1957 , and that death occurred at 3:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DS1 100 Professional Arts Bldg. 7-8-57 DATE SIGNED July 10 1957							
ACTUAL SIGNATURE W. T. Layman		M.D. 100 Professional Arts Bldg. 7-8-57					
PHYSICIAN'S NAME (Type) William T. Layman, M.D.		Hagerstown		Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/9/57	22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		22d. LOCATION (City, town, or county) (State) Sharpsburg Wash. Co Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown Md.			
24a. REC'D BY REGISTRAR July 10 1957		24b. REGISTRAR'S SIGNATURE John H. K. Bowers					

RECEIVED

CERTIFICATE OF DEATH

07953

Reg. Dist. No. 302

07940

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 50 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS 301 Garlinger Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Anna Virginia Wiebel				4. DATE OF DEATH Month Day Year July 1 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 19, 1892	
9. AGE (In years lost birthday) yrs. 64		10. IF UNDER 1 YEAR Months Days Hours Min. 12 hrs.		11. BIRTHPLACE (State or foreign country) Chambersburg Pa.		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Chambersburg Pa.	
13. FATHER'S NAME C. W. Hockersmith				14. MOTHER'S MAIDEN NAME Anna B. Newton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address John L. Wiebel Sr. Hagerstown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis, due to 420.1 DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0						INTERVAL BETWEEN ONSET AND DEATH 12 hrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 1957 to July 1, 1957 that I last saw the deceased alive on July 1, 1957 and that death occurred at 3:40 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Sidney Novenstein M.D.				ADDRESS (Street, city or town, state) DATE SIGNED 7-3-57			
PHYSICIAN'S NAME (Type) Sidney Novenstein							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		7-3-57		Rose Hill Cemetery		Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE			
Scott F. Minnich & Son Hagerstown Md.				July 6, 1957 Chas H Bowers			

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07954 305

07958

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boonesboro</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Reeders Nursing Home</u>		d. STREET ADDRESS <u>21 West Potomac</u>	
3. NAME OF DECEASED (Type or print) <u>Beryl</u> First <u>David</u> Middle <u>Wilson</u> Last		4. DATE OF DEATH <u>7-31-57</u> Day Month Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>11-5-1898</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Service Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew Young Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Flora May Crawford</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Mrs Paul Smith, Brunswick Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> <u>447X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>with hypertension -</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 22</u> , 19 <u>57</u> , to <u>July 31</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 30</u> , 19 <u>57</u> , and that death occurred at <u>2:14</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. W. Helman</u> M.D.		ADDRESS (Street, city or town, state) <u>Burnsboro - Md.</u>	
PHYSICIAN'S NAME (Type) <u>G. W. Helman</u>		DATE SIGNED <u>7/31/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-2-1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glenn Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. R. Lott</u> ADDRESS <u>Brunswick Md</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 2 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>John A. Burt</u>	

BUREAU A.

AUG 2 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 302

07941

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 19 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital				d. STREET ADDRESS 39 Fenton Ave.			
3. NAME OF DECEASED (Type or print) First Middle Last James Mansfield Wolford				4. DATE OF DEATH Month Day Year July 19 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 2, 1897	
9. AGE (In years lost birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 17		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tannery worker				10b. KIND OF BUSINESS OR INDUSTRY Tannery		11. BIRTHPLACE (State or foreign country) Downsville, Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Jacob Mansfield Wolford				14. MOTHER'S MAIDEN NAME Ida Kate Lindsey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. World War I 215-09-7410		17. INFORMANT Mrs. Ruth Byers, Williamsport, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 3 weeks 3 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 24 June, 1957, to 19 July, 1957, that I last saw the deceased alive on 19 July, 1957, and that death occurred at 5:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Paul Haak				M.D. 28 W. Patomac St.		DATE SIGNED 20 July 57	
PHYSICIAN'S NAME (Type) PAUL HAAK, M.D.				Williamsport, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-22-57		22c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		22d. LOCATION (City, town, or county) (State) Williamsport Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leaf Williamsport, Md.				24. REC'D BY REGISTRAR July 23, 1957		24b. REGISTRAR'S SIGNATURE Phyllis Bowers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

RECEIVED
JUL 24 1957
BUREAU V. 2

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. SIGNATURE OF PHYSICIAN	
10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF WITNESS		12. SIGNATURE OF DECEASED	
13. SIGNATURE OF FUNERAL HOME		14. SIGNATURE OF BURIAL PLACE		15. SIGNATURE OF INTERMENT	
16. SIGNATURE OF CEMETERY		17. SIGNATURE OF BURIAL		18. SIGNATURE OF INTERMENT	
19. SIGNATURE OF BURIAL		20. SIGNATURE OF INTERMENT		21. SIGNATURE OF BURIAL	
22. SIGNATURE OF INTERMENT		23. SIGNATURE OF BURIAL		24. SIGNATURE OF INTERMENT	
25. SIGNATURE OF BURIAL		26. SIGNATURE OF INTERMENT		27. SIGNATURE OF BURIAL	
28. SIGNATURE OF INTERMENT		29. SIGNATURE OF BURIAL		30. SIGNATURE OF INTERMENT	
31. SIGNATURE OF BURIAL		32. SIGNATURE OF INTERMENT		33. SIGNATURE OF BURIAL	
34. SIGNATURE OF INTERMENT		35. SIGNATURE OF BURIAL		36. SIGNATURE OF INTERMENT	
37. SIGNATURE OF BURIAL		38. SIGNATURE OF INTERMENT		39. SIGNATURE OF BURIAL	
40. SIGNATURE OF INTERMENT		41. SIGNATURE OF BURIAL		42. SIGNATURE OF INTERMENT	
43. SIGNATURE OF BURIAL		44. SIGNATURE OF INTERMENT		45. SIGNATURE OF BURIAL	
46. SIGNATURE OF INTERMENT		47. SIGNATURE OF BURIAL		48. SIGNATURE OF INTERMENT	
49. SIGNATURE OF BURIAL		50. SIGNATURE OF INTERMENT		51. SIGNATURE OF BURIAL	
52. SIGNATURE OF INTERMENT		53. SIGNATURE OF BURIAL		54. SIGNATURE OF INTERMENT	
55. SIGNATURE OF BURIAL		56. SIGNATURE OF INTERMENT		57. SIGNATURE OF BURIAL	
58. SIGNATURE OF INTERMENT		59. SIGNATURE OF BURIAL		60. SIGNATURE OF INTERMENT	
61. SIGNATURE OF BURIAL		62. SIGNATURE OF INTERMENT		63. SIGNATURE OF BURIAL	
64. SIGNATURE OF INTERMENT		65. SIGNATURE OF BURIAL		66. SIGNATURE OF INTERMENT	
67. SIGNATURE OF BURIAL		68. SIGNATURE OF INTERMENT		69. SIGNATURE OF BURIAL	
70. SIGNATURE OF INTERMENT		71. SIGNATURE OF BURIAL		72. SIGNATURE OF INTERMENT	
73. SIGNATURE OF BURIAL		74. SIGNATURE OF INTERMENT		75. SIGNATURE OF BURIAL	
76. SIGNATURE OF INTERMENT		77. SIGNATURE OF BURIAL		78. SIGNATURE OF INTERMENT	
79. SIGNATURE OF BURIAL		80. SIGNATURE OF INTERMENT		81. SIGNATURE OF BURIAL	
82. SIGNATURE OF INTERMENT		83. SIGNATURE OF BURIAL		84. SIGNATURE OF INTERMENT	
85. SIGNATURE OF BURIAL		86. SIGNATURE OF INTERMENT		87. SIGNATURE OF BURIAL	
88. SIGNATURE OF INTERMENT		89. SIGNATURE OF BURIAL		90. SIGNATURE OF INTERMENT	
91. SIGNATURE OF BURIAL		92. SIGNATURE OF INTERMENT		93. SIGNATURE OF BURIAL	
94. SIGNATURE OF INTERMENT		95. SIGNATURE OF BURIAL		96. SIGNATURE OF INTERMENT	
97. SIGNATURE OF BURIAL		98. SIGNATURE OF INTERMENT		99. SIGNATURE OF BURIAL	
100. SIGNATURE OF INTERMENT		101. SIGNATURE OF BURIAL		102. SIGNATURE OF INTERMENT	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07956

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1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>18 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Dargan</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Memorial Hosp.</u>				d. STREET ADDRESS <u>R.F.D.#1, Harpers Ferry, WVa</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>SAMUEL</u> Last <u>ZIMMERMAN</u>				4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 7, 1902</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Limestone Mine</u>		11. BIRTHPLACE (State or foreign country) <u>Dargan, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John Franklin Zimmerman</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Florence Myers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>332-01-0003</u>		17. INFORMANT <u>Weston M. Zimmerman</u> Address <u>R.F.D.#1, Harpers Ferry, West Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>442X</u> DUE TO <u>Nephro-sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardio-vascular disease</u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>527.1 Chronic Emphysema</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 year</u> <u>57 years</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u> </u> Day <u>19</u> Year <u> </u> Hour <u> </u> o. s. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>1950</u> , 19 <u> </u> to <u>July 2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July</u> , 19 <u>57</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>SHARPSBURG, Md.</u> DATE SIGNED <u>7/2/57</u> ACTUAL SIGNATURE <u>Walter H. Shealy</u> M.D. PHYSICIAN'S NAME (Type) <u>WALTER H. SHEALY M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/5/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Samples Manor Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Samples Manor, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Donald Zackler</u>				ADDRESS <u>Harpers Ferry, WVa.</u>		24. REC'D BY REGISTRAR <u>5/5/57</u>	
24a. REGISTRAR'S SIGNATURE <u>Shack Bowers</u>							

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